97th Congress
2d Session

SENATE

Rept. 97-314
Volume 2

VOLUME 2—APPENDIX
DEVELOPMENTS IN AGING: 1981

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

PURSUANT TO

S. RES. 45, MARCH 3, 1981

Resolution Authorizing a Study of the Problems
of the Aged and Aging

March 1 (legislative day February 22, 1982).—Ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE
89-645 O WASHINGTON : 1982

S143-2

SPECIAL COMMITTEE ON AGING

JOHN HEINZ, Pennsylvania, *Chairman*

PETE V. DOMENICI, New Mexico
CHARLES H. PERCY, Illinois
NANCY LANDON KASSEBAUM, Kansas
WILLIAM S. COHEN, Maine
LARRY PRESSLER, South Dakota
CHARLES E. GRASSLEY, Iowa
DAVID DURENBERGER, Minnesota

LAWTON CHILES, Florida
JOHN GLENN, Ohio
JOHN MELCHER, Montana
DAVID PRYOR, Arkansas
BILL BRADLEY, New Jersey
QUENTIN N. BURDICK, North Dakota
CHRISTOPHER J. DODD, Connecticut

JOHN C. ROTHER, *Staff Director and Chief Counsel*
E. BENTLEY LIPSCOMB, *Minority Staff Director*
ROBIN L. KROPF, *Chief Clerk*

LETTER OF TRANSMITTAL

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C. March 1, 1982.

Hon. GEORGE BUSH,
President, U.S. Senate,
Washington, D.C.

DEAR MR. PRESIDENT: Under authority of Senate Resolution 45, agreed to March 3, 1981, I am submitting to you the annual report of the Senate Special Committee on Aging, Developments in Aging: 1981, volume 2.

Senate Resolution 4, the Committee Systems Reorganization Amendments of 1977, authorizes the Special Committee on Aging "to conduct a continuing study of any and all matters pertaining to problems and opportunities of older people, including, but not limited to, problems and opportunities of maintaining health, of assuring adequate income, of finding employment, of engaging in productive and rewarding activity, of securing proper housing and, when necessary, of obtaining care and assistance." Senate Resolution 4 also requires that the results of these studies and recommendations be reported to the Senate annually.

This report describes actions during 1981 by the Congress, the administration, and the Senate Special Committee on Aging which are significant to our Nation's older citizens. It also summarizes and analyzes the Federal policies and programs that are of the most continuing importance for older persons, their families, and for those who hope to become older Americans in the future.

On behalf of the members of the committee and its staff, I am pleased to transmit this report to you.

Sincerely,

JOHN HEINZ, *Chairman.*

CONTENTS

Page
Letter of transmittal III
Reports from Federal departments and agencies:
Item 1. Department of Agriculture:
  Science and Education Administration 1
  Extension Service 2
  Forest Service 8
  Economic Research Service 8
  Rural Electrification Administration 8
  Farmers Home Administration 9
  Food and Nutrition Service 10
  Office of Equal Opportunity 13
Item 2. Department of Commerce 13
Item 3. Department of Defense 16
Item 4. Department of Education 17
Item 5. Department of Energy 24
Item 6. Department of Health and Human Services:
  Office of Human Development Services:
    Administration on Aging 33
    Administration for Native Americans 94
    Title XX 94
  Social Security Administration 95
  Health Care Financing Administration 104
  Public Health Service:
    Alcohol, Drug Abuse, and Mental Health Administration:
      National Institute on Alcohol Abuse and Alcoholism 156
      National Institute on Drug Abuse 158
      National Institute of Mental Health 159
    Food and Drug Administration 163
    Health Resources Administration 168
    Health Services Administration 174
    National Institutes of Health:
      National Institute on Aging 179
      National Institute of Arthritis, Diabetes, and Digestive and Kidney Diseases 195
      National Cancer Institute 196
      National Center for Health Statistics 203
      National Eye Institute 205
      National Heart, Lung, and Blood Institute 208
      National Institute of Neurological and Communicative Disorders and Stroke 209
  Office of the Inspector General 213
  Office of the General Counsel 214
Item 7. Department of Housing and Urban Development 218
Item 8. Department of the Interior 226
Item 9. Department of Labor 234
Item 10. Department of State 244
Item 11. Department of Transportation 245
Item 12. Department of the Treasury 252
Item 13. ACTION 256
Item 14. Commission on Civil Rights 260
Item 15. Comptroller General of the United States (General Accounting Office) 270
Item 16. Environmental Protection Agency 273
Item 17. Federal Communications Commission 274
Item 18. Federal Trade Commission 274

Reports from Federal departments and agencies—Continued

Page

Item 19. Legal Services Corporation 278
Item 20. National Endowment for the Arts 279
Item 21. National Endowment for the Humanities 294
Item 22. National Railroad Passenger Corporation 303
Item 23. Office of Consumer Affairs 305
Item 24. Pension Benefit Guaranty Corporation 310
Item 25. Postal Service 312
Item 26. Railroad Retirement Board 313
Item 27. Small Business Administration 316
Item 28. Veterans Administration 316

97TH CONGRESS } SENATE { REPT. 97-314
2d Session } { Volume 2

VOLUME 2—APPENDIX
DEVELOPMENTS IN AGING: 1981

—**Ordered to be printed**

Mr. HEINZ, from the Special Committee on Aging, submitted the following

REPORT
APPENDIX

REPORTS FROM FEDERAL DEPARTMENTS AND AGENCIES

ITEM 1. DEPARTMENT OF AGRICULTURE

DECEMBER 24, 1981.

DEAR MR. CHAIRMAN: This is a followup to our first response to your September 25, 1981, letter requesting an update of Department of Agriculture (USDA) programs and services for older Americans in fiscal year 1981, for inclusion in the "Developments in Aging" report.

Enclosed are reports obtained from the following USDA agencies: (1) Science and Education, (2) Forest Service, (3) Economic Research Service, (4) Rural Electrification Administration, (5) Farmers Home Administration, (6) Food and Nutrition Service, and (7) Office of Equal Opportunity.

We hope the reports will be helpful to the committee and to individuals and groups in the field of aging. Thank you for giving us the opportunity to submit to the Special Committee on Aging the annual reports from USDA agencies.

Sincerely,

JOHN R. BLOCK, *Secretary.*

Enclosure.

SCIENCE AND EDUCATION ADMINISTRATION

HUMAN NUTRITION PROGRAM IN AGING

A major new national facility for the study of human nutrition in aging is being constructed at a cost of $23 million on land donated by Tufts University. Construction is scheduled for completion in 1982. At that time research will be conducted into the ways in which diet, alone and in association with other factors, can delay or prevent the onset of the degenerative conditions commonly associated with the aging process. Research programs developed in the center will identify nutrient requirements during aging and the ways in which an optimal diet, in combination with other factors—heredity, constitutional, psychological, sociological, and environmental—may contribute to health and vigor over the lifespan of people.

The questions to be investigated are: (1) How does nutrition influence the rate of determination of various bodily functions as people grow older? (2) What role does nutrition play in retarding or advancing the development of chronic disabilities and disorders associated with aging? (3) What are the optimal nutritional needs for older people in order to maintain good health and bodily functions? A long-term program to answer these questions has been developed with the following components:

(1) Develop the capacity to perform epidemiologic and nutritional studies on adults of various ages, in order to demonstrate relationships between nutritional status, patterns of health, and body functions as age advances.

(2) Conduct studies of the functions of individual systems of the body during aging and the impact of previous and present nutritional factors on them.

(3) Investigate changes in human metabolism as age advances, and their relationships to nutrient intake and nutritional status.

(4) Development of special methodologies to study the dietary needs for protein, energy, vitamins, and minerals.

(5) Study the nutrient requirements of older adults for the following: (a) Dietary protein and factors affecting requirements for protein; (b) minerals, including trace minerals and their interactions; and (c) vitamins.

(6) Investigate effects of medicinal drug treatment on nutrient needs of elderly people.

(7) Examine the effects of nutrition and diet on tissue function of aging animals and the implications for the aging process in man, notably: (a) Interrelationships of diet and endocrine factors; (b) interaction of vitamins, minerals, and hormones in age-related loss of bone salts (osteoporosis); (c) role of diet in changing rate of loss of tissue function with age; and (d) uptake and utilization of vitamins and minerals in cellular metabolism and function.

During fiscal year 1981, the Human Nutrition Research Center on Aging at Tufts University was appropriated $3.7 million. Although the full research program requires the completed building, facilities made available by Tufts University has permitted the implementation of an interim research program.

Studies to determine the significance of dietary protein in maintaining tissue functions as aging takes place, as well as more fundamental studies of the effect of nutritional status on individual cells through life, are in progress. In addition to these studies, significant progress has been made in developing a program of nutrition evaluation of older Americans.

EXTENSION SERVICE

Program leaders in the national office of Home Economics and Nutrition, 4-H, and other Youth and Community Resource Development units provide leadership to aging programs of the Cooperative Extension Services in the States, District of Columbia, Guam, Puerto Rico, and Virgin Islands. National staff and resource allocations are made to enhance the quality and quantity of programs provided for the aging population at the county level. In addition, national leaders develop and coordinate joint programing and projects with many agencies and organizations, i.e., AoA, NIH, FDA, NCOA, AARP–NRTA, National Extension Homemakers Council, and the National Safety Council. Also, educational programs to meet the interests and needs of the aging are provided by State and county Extension professionals, paraprofessionals, Extension Homemaker Club members, and 4–H'ers and other youths.

Activities on behalf of older persons are reported below by the three program units.

HOME ECONOMICS AND NUTRITION

Extension Home Economics programs provide educational programs to individuals that assist them to maximize stability and security throughout their life cycle, to learn skills, increase competencies, and recognize alternatives needed to adjust to the impact of economic and social changes. All State Extension Home Economics programs are providing educational programs and information to one of the fastest growing population groups in this Nation—the aging: Special emphasis has been given to meet individual needs of preretirement and postretirement, intergenerational programs, and continued life enrichment. Emphasis on outreach to the elderly varies by State, dependent on local citizen needs. However, with the growing numbers of elderly and the special needs of this segment of the population, an increased effort was reported by 38 Extension Services to design programs and disseminate Home Economics programs to the aging. Below are selected examples of programs on inflation, energy, health and safety, clothing and textiles, family life, leisure and recreation, and food and nutrition.

Inflation

Managing family resources of time, energy, and money, has become a critical need for most families in this inflationary economy, especially for limited- and fixed-income individuals and families. More individuals have sought out Extension Home Economics seeking management skills of time, money, and energy. Approximately 12,000 Florida fixed-income or retired individuals attended educational programs taught by trained paraprofessionals to reduce energy waste substantially and manage resources more efficiently. Lessons were taught in five Illinois counties to help 3,157 homemakers understand the social security system so that they could make intelligent plans for their own retirement. Estate planning workshops in Kentucky attended by 1,500 Extension Homemakers of which 33 percent were senior citizens resulted in many attendees: Checking credit records, opening checking accounts in own name, reviewing status of bank accounts and status of account when spouse dies, reviewing and updating life insurance policies. Senior citizens in Ohio and Missouri participated in computer budget analysis workshops.

Energy

Programs focused on helping senior citizens make more efficient use of home energy were reported.

Examples: Six counties in Texas reported 500 low-income elderly homeowners took part in programs to aid them in improvements to maintain thermal comfort with minimal expenditure.

In Florida an "Energy Efficient Home" correspondence course reached 185 families, average age group between 45 to 64, with ways to save energy, and ultimately, money.

Missouri conducted an interior storm window project in senior citizens centers. Participants constructed a window to take home and install. This project was in cooperation with Northwest Missouri Area Agency on Aging and funded by the Missouri Department of Natural Resources. Cooperation was also obtained from the Reynolds Metals Co.

Health and Safety

Buying supplemental heatlh insurance is a problem for many senior citizens. Wyoming's 8,000 senior citizens in six counties received newsletters to explain health insurance, determine supplemental need, and purchasing of supplemental policies. Public meetings were also held at senior centers in six counties.

An estimated 3,000 older Americans in Wisconsin attended programs on health insurance medicare supplements. The Wisconsin Commissioner of Insurance assisted in planning and carrying out the program.

Training programs for professionals and paraprofessionals working in the field of aging are given in Mississippi. 161 participants who took 180 hours of intensive instruction have received a certificate of gerontology. The program is self-supporting and noncredit. The advisory board for the Certificate of Gerontology consists of representatives from 21 agencies and organizations.

A health screening fair in one county in Illinois, in cooperation with National Health Screening Council, the Red Cross, area agency on aging, County Council for Senior Citizens, and the Extension Homemakers, reached 200 persons over 60. The screening included a 25-channel blood test valued at $150; the savings to participants would be $30,000. Eight counties in Illinois cooperated with local health departments, hospitals, and Illinois Heart Association in conducting high blood pressure screening clinics for 3,000 individuals, 173 suspect conditions were identified, 10 identified as new hypertensives, 131 were screened for pulmonary functions, and 21 referred to physicians for followup diagnostic work.

Senior citizens in Florida and Kentucky received CPR training. "Health Promotion As An Individual's Responsibility" workshops were held in New Hampshire, Nebraska, Kansas, and Kentucky to promote better health habits.

Clothing and Textiles

Changing body shapes due to aging and physical disabilities create problems for the elderly in selecting apparel. Fine clothing for limited abilities workshops held in one county in Kentucky reached 160 persons, including relatives or persons in charge of purchasing and making clothing for nursing home residents and senior citizen centers. Over 600 leaflets relating to physically limited were distributed. Over 3,000 participated statewide.

Similar workshops were held in Minnesota, Illinois, and Georgia.

Family Life

Maine elderly are faced with several issues, notably geographic isolation, lack of adequate transportation, insufficient income maintenance, and high rates of unemployment. As a result of a contract for National Council on Aging funds, a Maine senior community service project has been continued and expanded. The project helps provide part-time job opportunities for workers 55 years of age or older, and has effectively reinvolved the elderly in the mainstream of life. 204 enrollees were employed by Cooperative Extension Service. In addition to training in the specific activity for employment, enrollees receive job development training in the goals, and technical information relative to the project, self-confidence building skills, assessing skills and strengths, setting job goals, and preparing for interviews and interviewing skills. This project has been adopted as a training module on the national level.

A half-hour educational television series, "Butterberry Hill," has been developed through cooperation with specialists and a commercial television station, reaching 13,000 homes in the northeast area of Kansas each month. Method is innovative in using puppets as teaching tools, as well as having teacher's guides to accompany each program, reaching 1,500 Kansas grade school classes. To counteract stereotyped attitudes about aging, the program incorporates various opportunities to express creativity of both youth and older adults.

Leisure and Recreation

Over 250 Texans from 90 counties have taken part in educational programs designed to help service organizations meet the leisure and recreation needs of older persons. Participants included: Senior adult center directors, nursing home activity directors, area agency on aging staff, American Association of Retired Persons, church volunteers, and Extension staff, and volunteers. The program emphasizes joint training of participants so appropriate linkages can be developed. More than 27,000 older adults have been reached.

Food and Nutrition

In Alabama, nutrition lessons for older persons were given at nutrition program feeding sites. The older persons reached ranked the monthly nutrition lessons according to worth to their lifestyles. Better food, more fun, meeting new people, saving money, and buying a greater variety of food were the top five ranked benefits to lifestyle. The "trim and slim" program reached elderly with information on weight control. Alabama also has a new series of "Food and Nutrition Lesson Plans for Leisure Years" to be presented by county home economists at senior sites. From talks on preparation of specific foods, the audience learns about nutrition, time management, and stretching the food dollar.

Arizona paraprofessional senior aides have taught 15,000 older persons how to stretch low and fixed incomes, how to conserve energy, and how to maintain optimal health and self-sufficiency by understanding the relationship of diet to health and practicing good nutrition and health habits. Many of the older persons reached are Hispanic. In Arizona's Maricopa County the Extension home economist employs elderly paraprofessionals to teach the elderly. 5,000 elderly are reached in that county.

In Arkansas, a total of 2,470 elder persons participated in nutrition learning experiences in eight counties, with a 40-percent knowledge increase and a 70-percent increase in milk consumption, 50-percent increase in consumption of vitamin C-rich foods, and a 20-percent increase in meal planning.

The Delaware Division on Aging together with the Cooperative Extension Service home economics program has developed extensive lesson plans, instructional materials, and audiovisuals to be used by trainers in the areas of nutrition and health education for the elderly. This Delaware nutrition and health education project for the elderly resulted in a manual of lessons on nutrition and health considerations for later life. The manual is entitled, "Life Changes." The lessons are taught by trained paraprofessionals. The goal of the lessons is to make elder persons aware of options available to them in the areas of nutrition and health, and to help expand or maintain personal independence.

In the District of Columbia, the elderly population is easy to reach and so Extension reached 5,000 elderly per year through talks at meal sites by cooperative work with the office of aging.

Utah developed SNAP, senior nutrition aid program, which has improved the diets of at least 3,000 elderly adults (60 years and older) in the southwest corner of Utah. The State division on aging also provided funds for personnel at Utah State University to design and deliver a program to improve the management of title III nutrition programs at senior citizen centers throughout the State. The emphasis for the training was on food service management and nutritional adequacy of diets. Also, the Utah State Division on Aging, in cooperation with the Utah State cooperative extension program and the University of Utah School of Medicine conducted a series of workshops designed to improve nutrition education for elder adults. The cooperative effort focused on developing a closer working relationship among Extension personnel, health professionals, and service providers.

Over 300 elders in West Virginia were reached through senior citizen programs with information on the interactions of foods, nutrients, and drugs.

Wisconsin has a coordinated media instructional project in food and nutrition for elder adults that reached over 5,000 elderly. The materials (press releases, radio spots, cartoons, lesson plans, factsheets, evaluation forms) now constitute a book that was made available to other State Extension Services.

As a result of educational programs and clinics, the elderly in Washington obtained a better understanding of the relationship of food and nutrition to disease. In two counties, as a result of ever increasing requests for nutrition education programs, an innovative program, a senior nutrition aide program, resulted. Each volunteer aide was asked to volunteer 40 hours of service for Extension, following a series of 12 training lessons covering basic nutrition, therapeutic diets, food fads, sanitation, and storage. The aides worked toward a certificate of achievement. The goal of the program is to provide volunteers with enough information to help guide their personal food choices and to help them be a direct link with the Extension office.

COMMUNITY RESOURCE DEVELOPMENT

Missouri

Only four States exceed Missouri in the number of people over age 65. Many of these people are faced with a tremendous increase in the cost of energy and services while the incomes are on a fixed rate and have remained constant. Extension has been working with citizen groups and agencies to define the problems and to plan and implement programs which will make the best use of resources to alleviate problems of senior citizens.

A Missouri Extension area Community Development specialist conducted area-wide training programs for 32 volunteers who work on a regular basis with senior citizens at the senior citizen centers in the region. He worked with the department of adult education, University of Missouri-Columbia, in conducting a series of educational programs for the elderly and volunteer leaders who work with the elderly. Subjects include: Wills and estate planning; energy conservation handling stress and tension in later years; consumer education for the elderly; understanding tax laws and Federal laws for older adults; and adjusting to older years.

Extension credit courses in gerontology are offered at the University of Missouri. An experimental correspondence course on gerontology was offered by the UM–Rolla Campus. Sociology faculty have participated in more than 14 workshops—for Extension field staff, State "purchase of service" workers, including several area agencies on aging, and other professionals working in private and public agencies for the elderly.

Surveys were conducted of the elderly population in the Ozark Gateway area. It was apparent from the results that people are not prepared for the sociopsychological problems of aging and retirement. Two themes seemed to dominate the responses—legal problems and leisure-time activities. Three senior citizen seminars, cosponsored by the Extension Committee on Aging and the Region X Area Agency on Aging, were held to increase the knowledge and understanding of elderly persons of the aging process and the community services and programs available to help them cope with the problems and concerns. Included among the resource persons for the seminars were: County circuit judges, attorneys, attorney general for the State of Missouri, chief counsel for the Consumer Protection

Division, recreation and parks specialist, and a recreation therapist. More than 250 people participated in these seminars.

Arkansas

Arkansas is another State with a large percentage of senior citizens. Health care and medical facilities are especially important to them. Arkansas has an outstanding program in recruiting doctors.

In Carroll County, the Carroll General Hospital was in danger of closing if additional doctors were not obtained. The Extension Service implemented a program to acquire doctors for Green Forest and Berryville. Surveys were conducted and a doctor recruitment and procurement program was initiated. A meeting of over 50 community leaders was held, including representatives of the University of Arkansas College of Medicine and the local medical profession. The doctor recruitment-procurement committee was established and officers elected. The committee has been very successful. They have been instrumental in recruiting three medical doctors to locate in Carroll County in 1981, and a fourth doctor is to intern with a practicing M.D. at Green Forest. A new medical building to be used by the doctors is also planned.

Georgia

Inaccessibility of health care is a serious problem among rural people of the South, particularly among the poor and the elderly. A major goal of the Georgia Cooperative Extension Service's health education emphasis is to motivate families to improve and maintain individual and community health. Two massive preventive health screening and educational programs were tailored to meet the needs of rural and urban Georgia. Community health fairs have involved volunteer assistance of over 62 local community groups, medical institutions, medical personnel, business, and site sponsors in order to offer the adult public a free screening program. While not restricted to the elderly, a large number of those participating were in the elderly age group. Screening included such tests as blood pressure, anemia, breast self-examination, tuberculosis, glaucoma, dental hygiene, etc., as well as counseling and referral.

A computer-assisted health prevention program was also implemented to estimate a person's chance of suffering a heart attack or stroke. Approximately 2,500 adults have participated in this program.

4-H AND YOUTH

Intergenerational programs are conducted by 4-H and Youth Extension staff in many States across the Nation. Generally, these programs center on:

- —Utilizing skills of senior citizens as resource persons for teaching youth special project skills.
- —Involving senior citizens as volunteer leaders for 4-H clubs and special units. It is estimated that about 10 percent of the 567,000 volunteer leaders in 4-H are senior citizens.
- —Promoting understanding and cooperation between senior citizens and youth.
- —Adopt-a-grandparent programs.
- —Promoting good nutrition among senior citizens.
- —Visiting and assisting senior citizens in nursing homes.
- —Helping senior citizens with home repairs, weatherization, gardening, and other activities around the home.

At the national level, two developments in the past year are expected to have an inpact on increased involvement of senior citizens in 4-H and youth programs nationwide:

- —4-H has cooperated with NRTA-AARP in a study to identify successful 4-H intergenerational programs and develop guidelines for 4-H staff and volunteers to promote this dimension of 4-H activities. As a result of this study, an excellent publication has been developed and distributed nationwide to State 4-H leaders and to State home economics staff members responsible for programs for the aging. This publication contains suggested areas for promoting 4-H intergenerational activities and should do much to increase efforts in this area.
- —One of the consulting groups at the 1981 national 4-H conference held in Washington, D.C., last April focused on programs for the aging. Youth, volunteers, and Extension staff discussed current programs and made a number of recommendations for promoting 4-H programs involving senior citizens.

These recommendations have been sent to all State 4-H leaders for implementation.

Alabama

Intergenerational programs in Alabama have been based on a model developed in Clay County. Older residents, 4-H'ers, and other interested adults met as an advisory committee to determine program interests and needs. Many worthwhile community programs, both of service and educational nature, resulted. Slides and tapes were made of this process and have been reproduced to share with each of the States.

Louisiana

About 450 4-H members in seven 4-H clubs in East Carroll Parish conducted 11 programs during holiday seasons last year for 100 elderly nursing home residents. Activities included making and delivering fruit baskets to senior citizens, giving potted plants, ~~and~~ providing entertainment activities to the elderly.

In another parish, 4-H'ers, 4-H agents, and older people participated together in 12 handicraft sessions, working on projects in basket weaving, leathercrafts, macrame, etc.

California

Through dialog sessions, 4-H members and AARP chapter members became aware of the pressing fear of crime which many elderly persons share. A community campaign against crime evolved. The Sonoma County crime prevention program cosponsored a series of meetings throughout the area to discuss crime prevention. Teaching aids included literature, films, and demonstrations on home security measures and the use of marking tools to engrave personal property. Other activities in Sonoma County included rural crime prevention, senior daycare projects, and a special mailbox security system. In the mailbox project, red markers were placed in the interior of mailboxes of participating older persons. If mail accumulated, the local letter carrier notified a local team that checked on the person. This system helped to alleviate problems due to illness or injury of persons living alone.

Also in Cailfornia, a program called "common ground," has been initiated as a part of California Cooperative Extension's community vegetable garden nutrition program. It offers a series of educational workshops that encourage people to grow their own vegetables as a means of fighting inflation, improving opportunities for better health, and providing fresher, tastier food. 4-H youth and older people work together on joint garden plots. Program development materials have been developed in English and Spanish.

Michigan

A successful program in Adger County, Mich., involved the forming of a 4-H club for older people. Main program leaders were 4-H members. The project encouraged dialog in a relaxed atmosphere, mutual acceptance, and the sharing of crafts and skills. At the end of the year's program, 4-H'ers received teen-leader pins, and older members received first year member pins for successfully completing membership activities.

Mississippi

Union County 4-H'ers began a project of community awareness by interviewing older people. About 30 young people and 30 older people took part in the activity. Not only did the two groups learn to appreciate and accept each other, but valuable history lessons and development of skills in writing, interview techniques, and communication also were learned.

Iowa

Many types of adopted grandparent-grandchild programs are in effect all over the county. In Taylor County, Iowa, a young woman with a great interest in local seniors, organized a group of friends which called themselves teen angels. They not only became good friends and shared experiences, ideas, and memories with senior friends, but conducted meetings to learn more about the process of aging, and the health and physical needs of the elderly.

FOREST SERVICE

SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM

The U.S. Department of Agriculture, Forest Service, in cooperation with the Department of Labor, sponsors the senior community service employment program (SCSEP). The SCSEP is authorized under title V of the Older Americans Act and provides part-time employment, work experience, and skills training to economically disadvantaged seniors, aged 55 and older, who reside primarily in rural areas.

Program participants are involved in projects on national forest lands such as construction, rehabilitation, maintenance, and natural resource improvement work. Enrollees receive at least the minimum wage to supplement their personal incomes. The SCSEP provides an opportunity for seniors to regain a sense of involvement with the mainstream of life, and the training provided by the program facilitates movement into public or private sector employment. Additionally, valuable conservation projects are completed on national forest lands.

Our July 1, 1981 through June 30, 1982, interagency agreement (for fiscal year 1981) with the Labor Department provided funding of $16.2 million which maintained the program at the previous year's level. We anticipate serving 4,500 seniors; we expect that 33 percent will be women and 20 percent will be minorities. These senior workers should accomplish 2,250 person-years of conservation work valued at more than $23.6 million. For each dollar invested in the program, we anticipate reaping $1.45 worth of conservation work.

ECONOMIC RESEARCH SERVICE

The Economic Development Division, Economic Research Service, has had an ongoing program of research on rural and nonmetropolitan elderly for several years. During fiscal year 1981, research topics included the demographic characteristics of the rural elderly, housing of the rural elderly, perceived benefits and problems of in-home services among elders, and transfer payments as a source of income in nonmetropolitan versus metropolitan areas.

Approximately $7,500 was allocated to research on general characteristics of the rural elderly and staff response to information requests from other agencies and organizations. The expenditures for research on housing of the rural elderly totaled approximately $5,000. The objective of the research was to compare housing of the rural elderly with housing of urban elderly and rural nonelderly.

A research report was completed that deals with staff and client perceptions of an in-home services program for senior citizens. This research was part of a larger study having the objective of determining the feasibility of in-home and community-based services as alternatives or deterrents to institutionalization. The report is a recent product of a study that was supported through a research agreement with the University of Arkansas based on fiscal year 1980 funding.

Another study that was underway in 1981 focused on the share of per capita income that transfer payments constitute, with comparisons by nonmetropolitan versus metropolitan areas. The objective of the study was to determine growth in, and dependence on, transfer payments as a source of income during the decade of the 1970's. Transfer payments comprise a higher proportion of per capita income in nonmetropolitan than metropolitan areas, and over two-thirds of transfer payments are from retirement programs such as social security. Approximately $50,000 was allocated to the study.

RURAL ELECTRIFICATION ADMINISTRATION (REA)

REA-financed electric and telephone systems must provide service to all residents of the areas they serve. Upon request REA does provide the REA borrowers with information about Federal financing and technical assistance available to help the elderly.

The most recent community development survey reveals that a number of the electric and telephone systems which are financed by REA are working with other community leaders on various projects for the elderly, i.e., housing, medical, transportation, and food distribution.

Although REA does not have the exact number, many elderly citizens are receiving home energy audits and other assistance from the electric cooperative to help save energy.

FARMERS HOME ADMINISTRATION (FMHA)

1. SECTIONS 502 AND 504 RURAL HOUSING LOANS

Section 504 rural housing loans are available to qualified low-income applicants to make basic repairs necessary to remove health and safety hazards. This includes such items as roof repair, storm windows, and doors, insulation, water systems, and waste disposal systems. The maximum loan is $7,500 and the interest rate is 1 percent. For the fiscal year 1981, $24 million is available for 504 loans. For elderly applicants who do not have repayment ability for a 1-percent loan, grant funds may be available for necessary improvements; $25 million is available in fiscal year 1981 for the grant program. This compares with $24 million available in 1980.

Elderly applicants may also be assisted under the section 502 loan program. Such loans are available to build, purchase, or rehabilitate modest homes that are adequate to fit the needs of the applicant. The interest rate on section 502 loans is currently 13¼ percent, with a maximum repayment period of 33 years. For low-income applicants, reduced interest rates are available to as low as 1 percent depending on income, number of people in the household, amount of loan installment, real estate taxes, and property insurance. Seventy-two percent of $2.3 billion available for section 502 loans in fiscal year 1981 is allocated to applicants who will qualify for the reduced interest rates.

Farmers Home Administration regulations have been amended to allow for adequate space to include elderly family members, such as parents or grandparents, as a part of the household.

2. SECTION 515 RURAL RENTAL HOUSING

The section 515 rural rental housing program provided approximately 31,000 units for $865 million in loan obligation during fiscal year 1981. Of this amount, it is estimated that 30 percent was expended to house the elderly. Many of these units were subsidized with FmHA rental assistance or by the Department of Housing and Urban Development (HUD) section 8 assistance payments. As of this writing, FmHA has not completed its program evaluation relative to assistance impact. Therefore, the figures given are solely estimates and should be considered as such. Under these programs, low-income elderly households pay up to 25 percent of their adjusted income for housing, including utilities. If their adjusted income is too low for them to pay the established rent, these subsidies make up the difference.

For fiscal year 1982, FmHA has budgeted $870 million for rural rental housing coupled with an additional $398 million for rental assistance. FmHA also expects to receive from HUD 4,000 units of section 8 set-aside funds to be used with the rental housing program.

The FmHA State Directors will be working on a State-by-State basis with their HUD counterparts to determine the ratio of elderly units to family and large family units to be subsidized by section 8 assistance.

Congregate Housing for the Elderly and Handicapped

Farmers Home has authority under the section 515 rural rental housing program to build congregate housing for the elderly who need an assisted residential living environment. It offers the functionally impaired or socially deprived but not ill elderly residential accommodations with supporting services to assist them in maintaining, or returning to independent lifestyles to prevent premature or unnecessary institutionalization as they grow older. The regulations provide for the establishment of the following mandatory services—meals, personal care and housekeeping services, transportation, and social and recreational activities. Developers who apply to Farmers Home for loans to build congregate facilities must demonstrate their ability to provide these minimum services. In most instances, developers are coordinating with social service agencies to obtain support in the provision of services.

The congregate housing for the elderly and handicapped program has been launched through a joint demonstration effort with the Administration on Aging of the Department of Health and Human Services (HHS). Farmers Home set aside $12 million for the construction of a congregate facility in each of the 10

HHS regions and two Indian reservations and the Administration on Aging provided up to $85,000 per facility for the support services named in the regulations. Sites were chosen based on the percentage of persons 62 years of age and older, income factors, and poor housing conditions. Housing has been constructed in Mayville, N.Y.; Baldwin, Mich.; Truth or Consequences, N. Mex.; Lamoni, Iowa; Wagner, S. Dak.; Beaumont, Calif.; and Baker, Oreg. Projects will be constructed in Port Gibson, Miss.; Onancock, Va.; and Carroll County, N.H.

Funding from the Administration on Aging for services will be available each year of the 3-year demonstration period after which the appropriate area agencies on aging have made commitments to continue the established services.

Due to the lack of funding from the Administration on Aging, the projects planned by the Turtle Mountain Tribe in North Dakota and the White Earth Tribe in Minnesota will be built as regular 515 housing for senior citizens.

Farmers Home and the Administration on Aging have received technical assistance from the International Center for Social Gerontology (ICSG) through training and consultation to national and field office staffs. Farmers Home has funded ICSG to evaluate the project through a subcontract to the American Institute for Research. The Administration on Aging has provided funds for ongoing technical assistance to the projects over the demonstration period. Missouri has replicated the demonstration effort through cooperative activities between social services agencies, the FmHA State office, and the developer.

Community Facilities Loan Division—Loan Payments That Impact on the Elderly

Community Facility loans are made to public entities and nonprofit corporations that primarily serve rural residents in towns or cities not to exceed 20,000 people.

These loans are made to construct, enlarge, or improve hospitals, clinics, nursing homes, community buildings, fire stations, or other community facilities that provide essential service to rural residents, and to pay necessary costs connected with such facilities.

Nursing Home

In fiscal year 1981, approximately 45 loans were obligated for nursing homes for some $35,175,300. These loans were in approximately 24 States. Nursing homes directly impact on the elderly in that they are almost wholly occupied by the aged.

Hospitals

Approximately 49 loans were made in fiscal year 1981 for hospitals. This amounts to approximately $45,997,500 and represents loans in almost 28 States.

Health Clinics

During fiscal year 1981, 34 loans were made for health clinics. These clinics were either for medical or dental services. The amount of funds loaned amounted to $11,429,200. Of the 34 health clinics, 30 were made under a joint agreement with the Department of Health and Human Services (HHS). These clinics are located in rural communities that are medically underserved. The HHS grants cover only operating expenses of rural health care projects, while FmHA loans cover the cost construction, enlarging, extending, or otherwise improving and equipping of community nonprofit health facilities.

Miscellaneous Projects

Miscellaneous projects include those facilities such as medical rehabilitation centers, nutritional centers, and vocational rehabilitation centers. During fiscal year 1981, 33 such loans were made for approximately $8,162,800.

FOOD AND NUTRITION SERVICE

The most recent tabulated data indicates that at least 2.026 million elderly persons (age 60 and older) are participating in the food stamp program. This figure is from October 1981. Participation has been increasing substantially since the food stamp purchase requirement was removed. Between November 1978 and November 1979, the number of persons 65 or older receiving food stamps increased by 42 percent. Over the same period, participation among the nonelderly increased only 26 percent.

It is estimated that elderly persons received about $1.175 billion in food stamp benefits in fiscal year 1981. This represents 10.4 percent of the total amount spent for benefits (approximately $10.6 billion). The average food stamp allotment per person, per month, was $39.48 as of September 1981. We do not have current figures for the average allotment which elderly persons or households receive.

We estimate that some 3.2 million elderly are eligible to receive food stamps. This rough estimate is actually the number of elderly who were below the poverty line in 1978 as given in the U.S. Census Bureau document, "Characteristics of the Population Below Poverty Level, 1978" (published June 1980). This number should be viewed cautiously for several reasons. First, it is based on 1978 data. Second, the census figure does not count assets which can disqualify for food stamps, applicants otherwise eligible by income. Third, it does not subtract the number of olderly people in SSI cash-out States, who are categorically ineligible for food stamps. (SSI cash-out is explained later.)

Last, some elderly persons whose gross income is above the poverty line, are eligible for food stamps, because certain deductions can be subtracted from their gross income during the certification process. However 3.2 million is as good an estimate as we presently have.

Especially in recent years, Congress and food stamp program administrators have been actively encouraging the elderly to participate in the food stamp program. Laws passed in 1977, 1979, and 1980, contained a number of special provisions aimed at easing participation for elderly persons and offering extra aid to households containing elderly members.

EASING APPLICATION

States must provide out-of-office interviews for elderly households who cannot or do not want to visit a certification office. Out-of-office interviewing can be done by telephone or by a prearranged home visit by an eligibility worker. Applicants may also designate a~~n~~ authorized representative to be interviewed for them to obtain their food stamp coupons and to shop with their food stamps. Also, some project areas arrange transportation to certification and issuance offices as part of their outreach programs.

Elderly persons applying for or receiving supplemental security income can apply for food stamps at their Social Security office instead of at a welfare office. (All persons in the household must be applying for or receiving SSI or be processed at an SSA office.) SSI/food stamp joint processing is one of several attempts to make food stamps more familiar, ~~acceptable,~~ and available to the aged by coordinating the food stamp program with more widely used elderly aid programs. State agencies are also required to inform SSI and social security households about food stamps. This has most often been done through enclosures sent with SSI and social security checks and notices.

SPECIAL ELIGIBILITY CRITERIA

Elderly households can have twice the countable assets other households can before becoming ineligible for the program. Most households are permitted $1,500 in resources; a household of two or more persons which contains at least one person 60 years of age or older, however, can have assets up to $3,000 and still be eligible for food stamps. Elderly parents living with their children or who have their children living with them may be certified as a separate household.

Persons 60 years of age and older are not required to register for work.

Special deductions for medical and shelter costs are available for elderly people:

(a) All nonreimbursed medical expenses of a person 60 or older, which are over $35 per month (excluding costs for special diets), may be deducted from a household's income.

(b) There is no limit placed on the excess shelter deduction which elderly households may claim. A household containing someone 60 or older may deduct all costs for shelter, which exceed 50 percent of its income after all other deductions. Other food stamp households may claim shelter costs over 50 percent of net income which, when combined with dependent care costs, do not exceed $115.

Households consisting entirely of elderly persons with very stable income can be certified for up to 1 year; the normal certification period is 3 months.

SPECIAL PROVISIONS FOR COUPON USE

Elderly persons and their spouses can use their food stamps to purchase meals at congregate eating facilities. Food stamps can buy meals served in senior citizens centers, senior citizen occupied apartment buildings, public or private nonprofit schools, and any other public or private nonprofit establishment that feeds senior citizens. Food stamps may also be used for meals at private establishments—including approved restaurants—which contract to sell meals to the aged at "concessional prices."

The elderly can use food stamps to buy prepared meals delivered to their homes by meals-on-wheels and similar organizations.

SPECIAL PROGRAMS

Two projects are being operated in conjunction with the SSI program in a number of sites to offer special aid to the elderly in obtaining nutritious diets.

An SSI "cash-out" program has been running in a few States since 1974. If States qualify and desire, they may add a fixed supplemental amount of money to all SSI checks instead of certifying eligible SSI recipients for food stamps. By law, the State must add at least $10 per month for single and two-person households out of its own funds; $10 is the minimum food stamp allotment for these households. By receiving aid in this way, elderly people are spared problems involved in certification and the embarrassment some feel in using food stamps. Currently, the only SSI cash-out States are California, Massachusetts, and Wisconsin.

A demonstration project, the SSI/elderly cash-out project, is now operating in eight States to test the feasibility and effectiveness of another method of cashing out food stamps for the elderly. Households consisting completely of persons 65 years of age or older, or persons receiving SSI benefits under title XVI of the Social Security Act, receive a check equal to the value of what their food stamp allotment would otherwise be. The check is issued by the State or local agency. The objective of this project is to try to increase the low participation of the elderly by removing perceived "participation barriers." These barriers are thought to include application procedures which are often difficult for the elderly or disabled, lack of transportation, and the "welfare stigma" associated with applying for and using food stamps. The effects on participation, nutrition, and administration will be evaluated to see if SSI/elderly cash-out should be implemented nationwide.

The demonstration project is operating in the following locations: Vermont (statewide), New York (one county), South Carolina (four counties), Ohio (one county), Minnesota (one county), Utah (statewide), Oregon (two regions; the area around Portland, and one other county), Virginia (one county).

FOOD DISTRIBUTION PROGRAM

USDA's substantial involvement in nutrition programs for the elderly, funded under the Older Americans Act of 1965 and administered by DHHS, began in 1974. Since that time, the food distribution program (FDP) has played an important role in providing USDA-donated foods or cash-in-lieu of the foods to the nutrition programs. The title III program administered through State agencies on aging and the title VI programs for Indians administered by tribal agencies provide for both congregate and home-delivered nutrition services to persons aged 60 or older and their spouses. Both of these meal services are eligible for food donations or cash-in-lieu payments at the new legislated level of 30 cents a meal for fiscal year 1981 as adjusted in the food-away-from-home series of the Bureau of Labor Statistics. Based on this adjustment, food donations or cash-in-lieu payments were provided on the basis of 47.25 cents per meal in fiscal year 1981.

Food donations provided to the nutrition programs in fiscal year 1981 included high protein meats or meat alternates, fruits, vegetables, grain products, and dairy products. The foods were purchased by USDA and shipped to States for their distribution to the nutrition programs. Cash assistance was provided to the States for disbursement to the nutrition programs. Nutrition programs use the cash to procure meals or foods used in the preparation of meals served to the elderly.

FISCAL YEAR 1981 STATISTICS

In the title III program for fiscal year 1981, 30 States elected to receive their entitlements in all cash payments. Three States elected donated foods only and 23 States chose to receive a combination of food and cash. This amounted to approximately $74 million in cash payments and $11 million in donated foods expended in that year.

According to data compiled by the Administration on Aging, USDA-donated foods or cash, were provided to 1,200 title III nutrition programs with 12,795 sites serving an estimated 168 million meals. The number of elderly and their spouses that were served through this program in 1981 was approximately 3 million persons. In addition, an estimated 19,000 elderly Indians participated in 85 title VI nutrition programs and were served over 1 million meals.

Aside from the elderly nutrition programs administered by the Administration on Aging, USDA makes a limited variety of foods obtained through price-support activities available to public or private charitable institutions which may be serving senior citizens. Among the institutions which are eligible to receive food to the extent of the number of needy persons served are nursing homes, senior citizens centers, and meals-on-wheels programs not participating under the Older Americans Act. In fiscal year 1981, charitable institutions received about $71.3 million in commodities which were made available to over 8,000 institutions serving an estimated 900,000 needy persons. Data on the number of elderly who are included with the estimated number of needy persons is not available.

OFFICE OF EQUAL OPPORTUNITY (OEO)

Office of Equal Opportunity (OEO) provides leadership and direction to assure equal opportunity in USDA programs and activities. As part of this function, OEO monitors the civil rights compliance status of the various USDA agencies which administer federally assisted and direct assistance programs and activities. Specifically, OEO monitors agency compliance with the requirements of title VI of the Civil Rights Act of 1964 and other Federal nondiscrimination laws which prohibit discrimination on the basis of race, color, religion, handicap, or age. OEO monitors the requirements of these statutes in federally assisted programs, direct assistance programs, and employment programs of the Department.

The Age Discrimination Act (ADA) was enacted by Congress in 1975 as an amendment to the Older Americans Act. The Office of Equal Opportunity has responsibility for development of USDA implementing regulations. Although the ADA would appear to exclusively protect the elderly, its protections are extended to members of all age categories. Final USDA regulations implementing the ADA are expected by the end of 1981.

In May 1976, the provisions of the Age Discrimination in Employment Act (ADEA) of 1976 were extended to include Federal, State, and local governments. The ADEA prohibits employment discrimination and protects persons between the ages of 40 and 75.

ITEM 2. DEPARTMENT OF COMMERCE

DECEMBER 21, 1981.

DEAR MR. CHAIRMAN: Thank you for your letter concerning Department of Commerce (DOC) programs pertaining to older Americans.

Enclosed is the Department's report for 1981, detailing five agencies' programs which benefit the older population, to be included in your committee's summary report. Since most of these programs are general in scope, the amount spent on activities relevant to the elderly is not easily identifiable.

Thank you for including the DOC in your support.

Sincerely,

MALCOLM BALDRIGE, *Secretary.*

Enclosure.

1981 REPORT ON AGING

BUREAU OF THE CENSUS

Statistical Reports

The following reports containing substantial amounts of data on older persons were issued by the Bureau of the Census in its "Current Population Reports" during 1981. The reports contain information about the demographic and socioeconomic characteristics of the population. Many of the "Current Population Reports" will be updated in 1982. Funding for these series is subsumed under general program expenditures and is not specifically identified.

Current Population Reports

	No.
Series P-20:	
Voting and Registration in the Election of November 1980 (advance)	359
School Enrollment: Social and Economic Characteristics of Students: October 1979	360
Persons of Spanish Origin in the United States: March 1980 (advance)	361
Population Profile of the United States: 1980	363
Marital Status and Living Arrangements: March 1980	365
Household and Family Characteristics: March 1980	366
Households and Families by Type: March 1981 (advance report)	367
Geographic Mobility: March 1975 to March 1980	368
Series P-23:	
Perspectives on Families Maintained by Female Householders, 1970-79	107
Noncash Benefits, Money Income and Poverty Status: 1979	110
Social and Economic Characteristics of Americans During Midlife	111
Child Support and Alimony: 1978	112
Series P-27:	
Farm Population of the United States: 1980	54
Series P-60:	
Money Income of Households in the United States: 1979	126
Money Income and Poverty Status of Families and Persons in the United States: 1980 (advance)	127
Characteristics of Households Receiving Noncash Benefits: 1980 (advance)	128
Money Income of Families and Persons in the United States: 1979	129
Characteristics of the Population Below the Poverty Level: 1979	130

Other Reports, Papers, and Ongoing Work

Preparation of a report, "On the Demographic and Socioeconomic Aspects of Aging in the United States," based on the most recent available data, for publication in series P-23, continued.

Paper, "Demographic Background for International Gerontological Studies," originally presented at the meeting of the International Association of Gerontology in Tokyo 1978, was published in the January 1981 issue of the Journal of Gerontology.

The Census Bureau is continuing its research on methods of projecting mortality in the United States.

Paper on "The 1980 Census and the Elderly: New Data Available to Planners and Practitioners," originally presented at the meeting of the Gerontology Society of America in San Diego, November 1980, was accepted for publication in the February 1982 issue of The Gerontologist.

J. S. Siegel's Presidential Address before the Population Association of America (Denver, May 1980), "On the Demography of Aging," was published in the November 1980 issue of Demography.

Background document is being prepared on behalf of the World Health Organization on the "Demographic Factors Affecting the Health of the Elderly to the Year 2000 and Beyond," for the United Nations World Assembly on Aging to be held in 1982.

Talk on the "Versatility of the Multiple Increment-Decrement Life Table as a Tool of Aging Analysis," at the Annual Meeting of the Gerontological Society of America in Toronto, November 1981.

Two special subject reports on the elderly, "Characteristics of the Older Population" and "Housing of the Older Population," based on the 1980 census, are being prepared.

Special tabulations on the age of householder were created from the Annual Housing Survey.

Update of Chartbook on Aging in America for the 1981 White House Conference on Aging.

NATIONAL OCEANIC AND ATMOSPHERIC ADMINISTRATION

The National Weather Service of the National Oceanic and Atmospheric Administration (NOAA) publishes daily weather forecasts which are very useful to all citizens. Specifically, this information is extremely important to the elderly. The forecasts of severe storms, extreme heat, pollution index, floods, tornadoes, and hurricanes provide advance information which helps older citizens plan and act on ways to avoid predicted weather which could cause a crisis. For long-range planning, NOAA's Environmental Data and Information Service (EDIS) makes information available concerning weather trends in various regions of the country.

At NOAA both the National Marine Fisheries Service (NMFS) and the National Ocean Survey (NOS) provide information that can be of importance to those retired citizens who wish to take part in marine recreational activities such as fishing and boating. Such information is supplied through recreation guides, charts, and other publications. Another NMFS publication is a monthly guideline pertaining to the "best buys" on fish for each geographic region. This informs the elderly of less expensive ways to fill their diet with high protein food.

NOAA continues to provide indirect assistance to the aged. During fiscal year 1980, the related programs and estimated expenditure levels were determined by using the latest available Bureau of Census percentage of elderly in the total population (11.3 percent). Therefore, the following estimates were derived (in thousands of dollars):

Programs:	*Fiscal year 1981 expenditures*
Regional weather trends—local weather dissemination, air pollution, weather services, climatic data services, environmental documentation and information services	$3,328
Recreational guides—nautical chart services, marine recreation fisheries	1,804
Fish food guidelines—economic and commercial fisheries statistics, fisheries development research and services, quality safety and consumer services	1,946
Total	7,078

NATIONAL TECHNICAL INFORMATION SERVICE (NTIS) PROGRAMS RELATED TO THE AGING

NTIS currently has an agreement with the Administration on Aging (AoA) by means of which NTIS enters and maintains in its computerized data base all existing and future AoA information, and which includes the promotion and dissemination of all AoA publications emanating from the AoA. This agreement also covers the microfilming and distribution to despositories throughout the United States of such materials, and the sales of items in the data base for which permission has been obtained.

PATENT AND TRADEMARK OFFICE

The Patent and Trademark Office continued the procedure that permits patent applications submitted by applicants who are 65 years of age or older to be "made special." This procedure allows the patent application to be taken up for examination earlier than its effective filing date would normally permit (section 708.02, Manual of Patent Examining).

There are numerous patents relating to drugs, disease prosthetics, and other devices that have a greater impact on the elderly than on the general population, but these patents are a byproduct of the total examining process.

NATIONAL BUREAU OF STANDARDS

Fire Research and Safety

Both the Health Care Finance Administration (HCFA) of the Department of Health and Human Services and the National Fire Protection Association's Life Safety Code have adopted the National Bureau of Standards (NBS) Fire Safety Evaluation System (FSES) for health care facilities. The system has also been cited by the President's Committee on Regulatory Reform as a desirable approach to the objective of improved, less restrictive regulations. As an analytical tool, the system determines if a hospital or nursing home has the level of fire safety protection prescribed by the Life Safety Code. When retrofit of an existing building is required, the system permits more flexibility in selecting the fire protection features to be used in obtaining the needed level of fire safety than a prescriptive code. This flexibility frequently results in significant cost savings without sacrifice of safety to both upgrading existing buildings and in the design of new buildings or major renovations.

A special FSES covering community-based residential care facilities is nearing completion. Such facilities serve the aged and other special groups (e.g., developmentally disabled) which do not need the degree of care or restraint and high costs of formal institutions. Some of these facilities have recently been involved in disastrous and tragic fires. The system, now nearing completion, covers the wide range of building sizes, residential needs, and levels of care required. NBS is submitting a proposal to the National Fire Protection Association to include a new classification of occupancy specifically recognizing these residences in the Life Safety Code along with the evaluation system.

NBS has recently completed extensive work on testing and evaluating the fire risk presented by mattresses selected for health care facilities. Mattress combustibility is often a major factor in determining whether a fire is a minor or major incident. Our proposed specification that will permit the procurement of mattresses on the basis of combustibility is now being disseminated to the health care industry by HCFA. Similar work is under way on determining the true combustibility involved in wardrobes and other furniture. A test program on sprinkler systems suitable for retrofit installations in facilities for the elderly is also in progress.

Dental Materials

NBS research in dental materials has been directed for over 50 years toward developing composite materials with greater durability and year resistance and toward improving base metal alloy alternatives to the costly gold prosthesis. Current efforts are directed, in part, toward upgrading the quality of composite restorative materials with regard to durability, adhesiveness, storage stability, and color. A silver staining technique developed in a study of wear mechanisms in restorations is yielding promising results. This technique differentiates between the effects of wear observed in clinical samples and those produced under laboratory accelerated test conditions. In addition, work is continuing on the development of new alloy ceramics, their fusion to base metals, and on the deterioration of dental amalgams.

Synthetic Implants

Bureau scientists are conducting research on the properties and performance of a number of alloys for use in metallic surgical implants. Special emphasis is being placed on how the performance of cobolt-chromium-molybdenum alloys and titanium alloys is affected by processing variables. Further, an improved test methodology is being investigated for characterizing the porosity of polymeric implant materials. A test method for measuring molecular weight, the most important molecular property of ultrahigh molecular weight polyethylene used for orthopedic implants, has been developed. The proceedings from the NBS conference on "Implant Retrieval: Material and Biological Analysis" were published this year. More than 500 copies were distributed. In addition, NBS staff made significant contributions to a number of voluntary standards groups, especially the American Society for Testing and Materials F-4 Committee on Medical and Surgical Materials Devices.

Listed below are the expenditures during fiscal year 1981 for these programs (in thousands of dollars):

Programs:	
Fire research and safety	$853
Dental materials	905
Synthetic implants	306
Total	2,064

ITEM 3. DEPARTMENT OF DEFENSE

December 21, 1981.

Dear Mr. Chairman: Thank you for your letter requesting a report on Department of Defense (DOD) actions and programs related to aging.

This Department continues to operate a comprehensive retirement planning program for Defense Federal Service employees. Integrated into the overall personnel management process, our program is designed primarily to assist employees in their adjustment to retirement and to assist management in planning for replacement manpower needs. It encompasses extensive preretirement counseling for employees (and their spouses in many instances) on such subjects as financial planning, health needs, leisure time activities, living arrangements and personal guidance. The program also includes trial retirement and gradual retirement options for employees where feasible. We believe our program helps alleviate many of the problems that employees have encountered in the past when approaching retirement age. We expect to continue the operation of the program in 1982.

The military departments and the defense agencies, in cooperation with community health officials, continue to provide a number of occupational health programs and services to employees, and in some cases to former employees who have retired. Many of these programs and services are designed to address problems generally associated with increasing age. Included are health guidance and counseling, periodic testing for diseases and disorders immunizations and treatments.

Within DOD, we continue to eliminate discrimination based upon age. We are examining personnel policies, practices, and procedures for possible conflict with equal employment opportunity intent, including discriminatory use of age.

In summary, this Department has operated a comprehensive retirement planning program for civilian employees, provided extensive health care services to employees, and carried out a positive program to preclude discrimination based on age. These program efforts will be continued in 1982.

Sincerely,

CASPAR W. WEINBERGER, *Secretary.*

ITEM 4. DEPARTMENT OF EDUCATION

JANUARY 15, 1982.

DEAR MR. CHAIRMAN: Thank you for your letter requesting current information from the Department of Education to be included in part 2 of "Developments in Aging," the annual report of the Senate Special Committee on Aging. I apologize for the delay in responding.

In accordance with your letter, I am happy to enclose the updated material for the adult education program.

If I may be of further assistance, please let me know.

Sincerely,

T. H. BELL, *Secretary.*

Enclosure.

ADULT EDUCATION

The U.S. Department of Education is authorized under the Adult Education Act, Public Law 91-230, as amended, to provide funds to the States and outlying areas for educational programs and support services benefiting all segments of the eligible adult population. It is the purpose of the act to encourage the establishment of programs of adult education that will enable adults 16 years of age and older:

(1) To acquire basic skills needed to function in society; and

(2) To assist them in continuing their education until completion of the secondary level, if they so desire.

Those adults who have completed the secondary level but are functioning at a level below are eligible to participate in the program. Students seeking employability skills are also *given the means* to secure training which will help them to become more employable, productive, and responsible citizens. Federal funds support up to 90 percent of each State's program, and up to 100 percent of the program in outlying areas. At least 10 percent of each State's allotment must be used for special experimental demonstration projects and teacher training. In addition to the State-administered program the act authorizes educational programs for adult immigrants. Two other provisions of the act, planning grants to States, and a national development and dissemination program, were included in the 1978 amendments to the act. Funds, however, have not been appropriated by the Congress to implement these two sections.

The 1978 amendments to the act generated a new national debate and increased concern for the educational needs of adults in the United States who are "least educated and most in need of assistance." Included in this segment of the American population are adults with special needs who are: Older persons, rurally isolated and migrants; located in urban areas of high employment; minorities; handicapped; immigrants; refugees; not proficient in the use of the English language; and women. States are encouraged to develop new and innovative approaches to expand outreach in order to effectively meet the needs of these underserved populations. The 3-year plan developed by each State and outlying area recognized this problem and proposed the targeting of some resources to increase access to, and the availability of, programs and services. Some State agency programs giving emphasis to meeting the special needs of the elderly are described in this year's progress report, and reflect a growing awareness of changing demography, differences in educational attainment levels, and shifting generational expectations.

In the 1974 report of the National Advisory Council on Adult Education, it was revealed that:

"Among adults 16 years of age and over who have less than a high school education and are not currently enrolled in school, two out of three are 45 and over; one in four is 65 or older. Of those with less than a high school education, more than three-quarters of those 65 and over have not completed grade school. Also the elderly with less than a high school education disproportionately represent higher public assistance rates." (These figures reflect both lesser levels of education which impact upon work force status as well as age-related disabilities.)

In 1975, data were released from the adult performance level project, funded by the Division of Adult Education, U.S. Office of Education. In this study of a random sample of a cross section of the U.S. population there are significant findings regarding the levels of skills and knowledges acquired by older adults and their ability to function successfully in today's society. The APL study reported that older persons 55 to 65 years of age comprised the largest percentage of persons who were functionally incompetent (35 percent) or were only marginally competent (40 percent). Only 24 percent of this age group were found to have sufficient knowledge and skills to cope in American society. ("Adult Functional Competence: A Summary," adult performance level project, the University of Texas, Austin, Tex. (March 1975, p. 7).

EXAMINATION OF AGE DIFFERENCES IN RELATION TO ADULT PERFORMANCE LEVEL KNOWLEDGE SUBSCORES

[Figures in percent]

Age Group	Occupational knowledge subscore	Consumer economic subscore	Government and law subscore	Health subscore	Community resource subscore
18 to 39:					
Adult performance level 1	12.2	25.0	21.0	17.3	16.3
Adult performance level 2	34.7	31.2	27.4	29.5	25.5
Adult performance level 3	53.2	43.8	51.5	53.2	58.2
40 to 54:					
Adult performance level 1	23.9	29.9	28.2	21.0	24.0
Adult performance level 2	26.7	34.4	26.5	31.7	25.1
Adult performance level 3	49.4	35.7	45.3	47.3	51.0
55 to 65:					
Adult performance level 1	33.4	42.7	37.2	35.3	40.6
Adult performance level 2	31.7	36.4	21.9	30.7	29.2
Adult performance level 3	34.9	20.8	41.0	33.9	30.3

Note.—

Adult performance level 1: Adults who are, by and large, functionally incompetent.

Adult performance level 2: Adults who function in society on a minimal level.

Adult performance level 3: Adults who are proficient in their mastery of competency objectives and function successfully in society.

EXAMINATION OF AGE DIFFERENCES IN RELATION TO ADULT PERFORMANCE LEVEL SKILL SUBSCORES

[Figures in percent]

Age group	Adult performance level— Reading subscore	Problem solving subscore	Computation subscore	Writing subscore
18 to 39:				
Adult performance level 1	16.6	24.2	28.1	9.0
Adult performance level 2	30.9	25.1	25.0	24.9
Adult performance level 3	52.4	50.1	46.9	66.1
40 to 54:				
Adult performance level 1	24.2	28.3	36.4	19.4
Adult performance level 2	31.9	21.1	24.5	23.4
Adult performance level 3	43.9	50.6	39.1	57.2
55 to 65:				
Adult performance level 1	34.0	40.0	42.4	35.7
Adult performance level 2	37.0	22.1	33.8	31.2
Adult performance level 3	29.0	37.9	23.8	33.2

Note.—

Adult performance level 1: Adults who are, by and large, functionally incompetent.

Adult performance level 2: Adults who function in society on a minimal level.

Adult performance level 3: Adults who are proficient in their mastery of competency objectives and function successfully in society.

~~In regard to our society's changing values and the benefits~~ of higher education, Dr. Carol E. Kasworm reported in a paper presented on "Adult Illiteracy" at the 1981 National Adult Education Conference, that the median number of years of schooling completed by the elderly have not been commensurate with the rise evident in the general population. Dr. Kasworm reported, from her review of a research study, that:

"Between 1940 and 1976, the median educational attainment of persons 25 years of age and over rose steadily from 8.6 to 12.4 years.

"For elderly persons, who received most of their education during and before the depression of the 1930's, the median number of school years remained at slightly over 8 years in the decades between 1940 and 1960. Since 1960, the median for the elderly has risen from 8.3 to 10.3 years, and this figure can be expected to rise to 12 years around the year 1990. Although the overall median for the elderly participation was 10.3 in 1976, this figure ranged from 11 years for the 60 to 64 age group to about 6 years for persons 75 and over. (Fowles, 1978; NACAE 1974.)

"The two charts, figures 1 and 2, both note the downward sloping of percent of school years completed with the increasing age categories, and also the present day rates of decreasing participation levels in adult basic education with increasing age categories. As noted by other research (Cross, Valley, et al., 1974; Johnstone and Riveria, 1965), there has been shown to be a direct inverse correlation between the relative age of the individual and the attained years of formal school involvement. Second, within adult basic education, in relation to previously cited research on adult continuing education, the level of participation in formal learning activities is also inversely correlated to incremental age groups."

FIGURE 1

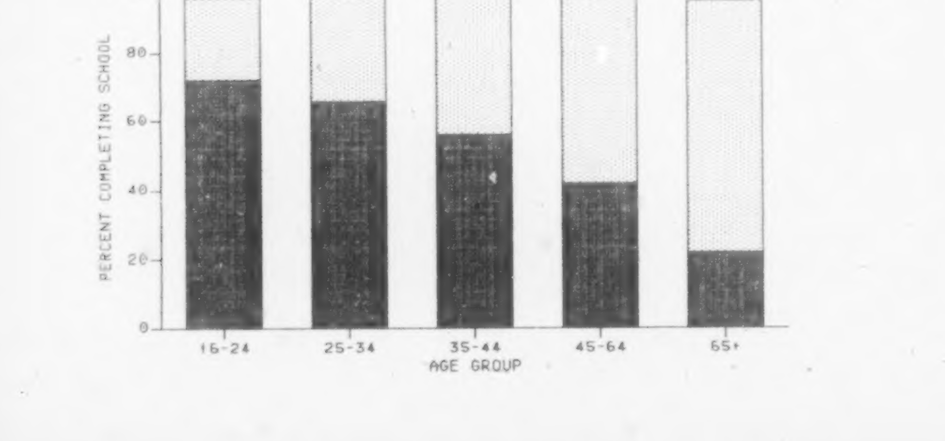
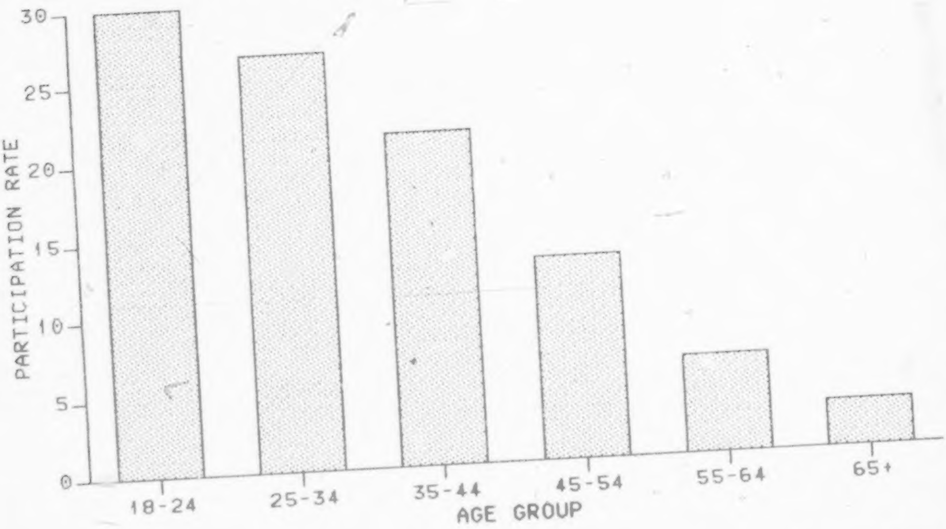


FIGURE 2

RATE OF PARTICIPATION IN
ADULT BASIC EDUCATION AND EQUITY PROJECT
BY AGE



These age differentiated characteristics are challenging to administrators and instructors planning and developing comprehensive educational programs and instructional strategies to meet the present and future needs of older adults.

Historically, changes in society have influenced other generational changes where age is a significant factor. Currently older adults are found to have not only higher rates of illiteracy but also more predominant representation of English-as-a-second-language orientation. Dr. Kasworm further reports from an analysis of Bureau of the Census data:

“According to the U.S. census, the number of persons 60 years old, born abroad, increased steadily from about 1.5 million at the turn of the century, to 4.2 million in 1960, a result of the aging of the large number of the pre-World War I immigrants. Between 1960 and 1970 this number declined from 4.2 million to 3 million and was projected to continue the decline into the future.

“A recent survey by the Bureau of the U.S. Census (Fowles, 1978), reported that 5 percent of 1.9 million persons 65 years of age and older, spoke a language other than English. The usual speaking language for half of these persons was either Spanish (30 percent) or Italian (20 percent).”

In recent years, efforts were undertaken to provide instruction in English and other basic literacy skills for immigrants and refugees. The Indochina Migration and Refugee Act of 1975, Public Law 94–23, was passed in order to provide the integration of the Indochina refugees into American society. Sections 317 and 318 of the Adult Education Act also authorized the support of programs for Indochina refugees and other immigrants. The adult Indochina refugee education program was authorized, and $5 million in 1976, and $10.25 million in 1977, were appropriated to be administered by the Division of Adult Education Programs.

In fiscal year 1980, an additional $2.5 million was appropriated for the Indochina refugee program, $2.5 million for programs for immigrants, and $17.6 million for programs for Cuban and Haitian entrants. At that time, to meet the growing needs of the immigrant and refugee populations, the Division of Adult Education established a branch to administer these three ESL programs.

From the $22.5 million appropriated for adult refugee and immigrant programs, 52 local projects were funded. These projects are serving approximately 50,000 immigrants and refugees. Programs provide English language training and other basic skills necessary to allow the refugees and immigrants to become self-sufficient in our American society.

The refugee and immigrant programs provide services to adults 16 years of age and older. Among the participants are older adults. It is estimated that approximately 400 adults, age 60 or older, are enrolled in ESL programs administered under the Adult Education Act. Since employment is not the major goal for the older immigrant or refugee, English language training and skill training is focused more on consumer economics, health, and understanding and using community services available in this country.

The need of many older Americans for instruction in English and other basic skills is a continuing challenge to the adult education program. Delegates to the recently held White House Conference on Aging expressed concern for the immigrants, refugees, and other elderly persons whose ability to speak and read the English language is limited, and who live in an area with a culture different than their own. For the purpose of assisting these older persons, an informal group expressed belief that the Conference should recommend to the Congress the appropriation of such funds as may be necessary to implement section 311 of the Adult Education Act, "Special Projects for the Elderly."

Another use placed high on the Conference agenda was job training and retraining programs. The delegates recognized the critical impact of the level of income and financial support have upon the life and future stability of older persons. It is recognized by specialists in the field that a major proportion of those adults who are "least educated and most in need of the program" have income at the poverty level and below.

Dr. Kasworm in addressing this factor in an analysis of income data concluded that:

"There has been a decline in the older adult representation of poverty level population from 5.9 million in 1969, to 4.3 million in 1976. These 4.3 million elderly poor represented one-seventh of all noninstitutionalized persons 60+ years old. In 1979, one-seventh of the population or 3.6 million older persons, 65 years and above, were defined as poor by official definition ($4,364 for a household of an older couple or $3,472 for an older individual living alone). However, current elderly who are below poverty level of income also are incorporated into a larger and growing group of 'near poor' level elderly. This subgroup is experiencing slower rates in decline in poverty or no decline at all, particularly those older subgroups of females, minorities, and those who live alone. This subgroup of the 'near-poor' also represents many older adults who do not qualify for social security benefits."

The adult education program is required to assist these older adults to more effectively cope with low income and low educational attainment levels. The realization of these complex and difficult program goals requires the implementation of long-term as well as short-term planning and development strategies. Maintaining or locating employment is particularly difficult when over one-half of the workers, 65 years and over, are without a high school diploma (Spengler, 1976). Eli Ginzberg noted that the greatest problem of older workers continuing employment was a lack of competence associated with inadequate education. This phenomenon is becoming increasingly significant as American society moves rapidly into a more technologically based era. "Technical literacy" is becoming a requirement for all age groups seeking new jobs or desiring to continue employment in current jobs, as agriculture-related and semiskilled occupations continue to decline.

These are some of the major factors undergoing serious examination by adult and vocational educators, and accomplishments realized in fiscal year 1981.

Under section 304 of the Adult Education Act there has been an annual increase in the number of students 65 years of age and over enrolled in the program from 128,612 in fiscal year 1980, to 130,757 in 1981 (2,145). This increase in enrollments has occurred despite inflation, increased program costs, and no increases in the level of Federal funding.

TABLE I

	Estimate	Percentage
Age group:		
16 to 44	1, 660, 318	80. 7
45 to 64	266, 907	13. 0
65 and over	130, 757	6. 4
Total	2, 057 982	100. 0

The estimated increase in enrollments of participants by age groups in 1981:

TABLE II

	Estimated enrollment	Estimated increase	Percentage increase
Age group:			
16 to 44	1,660,318	171,413	10.3
45 to 64	266,907	4,946	1.8
65 and over	130,757	2,145	1.6
Total	2,057,982	178,504	8.6

Inadequate knowledge about aging and no increase in the funding level required rethinking and redirection of program priorities and objectives nationwide. Priority attention was given to program improvement and the conduct of research studies under sections 304 and 310 of the act.

TEXAS

Currently 7 percent of the participants in the adult basic education program, in the State of Texas, are age 65 years and above.

The Texas Education Agency funded the department of curriculum and instruction, University of Texas, to conduct a section 310 project to research the current "state of the art" of their adult basic education program's outreach to older adults.

Other project objectives included: (a) The design of a staff development package to assist in the recruitment and instruction of older adults; and (b) creation of recruitment information resources for directors of adult basic education cooperatives.

Dr. Carol Kasworm is the project director and reports the deveolpment of the following products:

(1) A general model for recruitment and retention presented in a monograph, "Recruitment and Retention of Older Adults." Copies of the monograph were distributed to the directors of Texas Adult Education Cooperative, and presented at regional conferences.

(2) Outreach resource materials:

(a) Five 30-second public service TV announcements in both English and Spanish, and targeted to adults age 45 and above, in seven adult education cooperatives with high concentration of illiterate elderly adults.

(b) Two slide/tape programs in a staff development packet designed to improve the effectiveness of teachers working with older adult learners.

(c) A "Director's Guide to Recruiting Older Adults." This guide presents an overview of the current status of illiteracy in the older adult population, the conditions necessary for successful recruitment and retention of older adults, and specific recruitment strategies to enhance outreach activities; and

(d) "Implementing Programs for Senior Adults in Residential Facilities."

Items (b), (c), and (d) will be disseminated to all 49 Texas Adult Education Cooperatives.

GEORGIA

The State Education Department of Georgia funded the Georgia Center for Continuing Education, University of Georgia at Athens, to survey programs for the elderly, and to identify the educational needs of older adults throughout the State. Interviews were conducted on 500 Georgians 60 years of age and older. Fourteen percent of the total State population is in this age category, and 37 percent are below the poverty level.

The mean age of those interviewed in the survey was 72.1 years, with 58.1 percent of the respondents having incomes below the poverty level.

An outline for an instructional manual is being developed based on the survey findings and offers a significant beginning to a soundly conceived statewide program.

MICHIGAN

The Michigan State Department of Education accepted the challenge of innovative educational programming for older learners by funding a section 310 project to the Monroe County Adult Education Consortium of the Bedford Public School System, Monroe, Mich. The project study research was undertaken "to design and validate procedures for insuring quality adult education in nursing homes and convalescent centers." The study addressed three broad issues: educational gerontology, institutionalization, and professional dissemination.

The need for the study was documented in a memorandum issued by the Michigan Department of Mental Health. The directive states in part:

"The elderly are dramatically underserved by the community mental health system. While representing only 5 percent of the elderly, nursing home residents display behavioral and emotional problems of untenable proportions. Estimates of the incidence of mental health problems among this population consistently approach 50 percent. Prior to the adoption of the current Mental Health Code, two-thirds of this at need population met the admissions criteria for State hospitals. This fact, combined with the deinstitutionalization of older people from State hospitals into nursing homes, has created the situation where there are now more mentally ill older people in nursing homes in Michigan than in State hospitals. Although legally residents of CMH catchment areas are eligible for services, few CMH boards have identified older adults in nursing homes as a target population. The legislature has now recognized the role of community mental health boards in nursing homes with the requirements for consultation and service agreements."

The SAEP staff identified two educational needs:

(1) The life-changes that most institutionalized elderly are experiencing can be positively affected by an educational intervention.

(2) Instructors of institutionalized elderly need training in these life-changes to enable them to present classes in an appropriate manner.

The report of a 1 year documentation and analysis effort conducted in nursing homes to validate the process in operation indicated that a beneficial change occurred due to educational intervention. The field of adult education benefits by moving closer to the development of replicable standards in serving the elderly suffering from debilitating effects of institutionalization.

MARYLAND

The Maryland State Education Department took steps in many directions using section 310 funds to improve the quality of the adult basic education program. A project grant to the Montgomery County Public Schools was planned to explore the feasibility of using volunteers to work with the 0–4 level adult learners, and to encourage volunteer program development statewide. Forty-six volunteers were trained in the project; 37 of this number are 60 years old and over. Plans are underway to increase the number of trained older volunteers to serve the 8,193 adults 60 years of age and older currently in the program.

RURAL ADULT BASIC EDUCATION PROJECTS

In 1980–81, 42 projects were implemented by the States to expand and improve educational services to those adults living in rural, isolated, and remote areas.

CALIFORNIA

The Elsinore Union High School District was funded by the California State Department of Education to develop 200 telecentered learning experiences (TELEX) to teach basic communication and computation skills to rurally isolated adults. The project utilized cable TV as the educational delivery system for home-based instruction. While all segments to the adult population are included, three projects focused directly on those 60 years and over.

ALABAMA

In Monroeville, a curriculum guide was developed for "Mature Adults at Nutrition Sites" in three counties: Monroe, Baldwin, and Escambia.

LOUISIANA

The plantation education program in the State of Louisiana provides adult basic education in three parishes of southwest Louisiana. This outreach effort serves other residents of remote rural areas, and in particular those on plantations, i.e., Katy, Oaklawn, and Oxford Plantations. Intensive efforts are carried out to locate, motivate, and result the older adults in these areas and to provide home-based instruction to stimulate interest throughout the year.

ARKANSAS

The Pulaski County Adult Education Center of Little Rock, Ark., conducted a senior citizen's outreach program around the central area of Little Rock. With flexible scheduling and cooperation with the five residential homes for the elderly about 700 persons are incorporated into the regular adult basic education classes.

Priority attention is also being given to older adults with special needs, such as those in correctional institutions and the handicapped.

TEXAS

The Windham School District in Huntsville, Tex., developed a model program for a geriatric educational program in a correctional institution. This program is a pilot for use in the Texas Department of Corrections.

The San Angelo Independent School District in San Angelo, Tex., developed teaching modules specifically designed for use with middle-aged persons with mild and moderate mental retardation, who have been institutionalized and out of the mainstream of society for several years. The teaching modules will identify the necessary techniques, materials, and specific strategies to be used in preparing these handicapped adults to regain a productive life both vocationally and personally.

Nationally, two major developments were undertaken as part of the development strategy to encourage the expansion of programs for the elderly:

(1) White House Conference on Aging, 1981. Staff support was provided conference program staff on educational issues surfaced during the preparatory planning phase, and in meeting the needs of the delegates/observers engaged in a discussion of educational issues and development of recommendations on educational policy on aging.

(2) National Adult Education Conference, 1981. An all-day forum series on "The Application of Telecommunications and Computer Technologies in Adult Education: Policy and Program Issues for a Development Strategy": (a) Highlighted some of the significant developments in the State-administered adult education programs; and (b) shared technical information and insights gathered from the use of educational telecommunications and computer technologies useful for improving the quality, increasing accessibility and availability of adult education programs.

The States of *South Carolina* and *Illinois* reported on the findings of significant research projects funded by the National Science Foundation to experiment with the delivery of high school equivalency and teacher training activities using interactive cable (TV).

The State of *Utah* presented a progress report on an experiment using the intelligent videodisc system to improve the teaching of mathematics.

Presentations from the States of *New York* and *California* focused on developments in progress to meet the growing needs for quality software for the new technology systems.

Policy issues were addressed by Secretary T. H. Bell in a speech telecast to Anaheim's conference site and five cities (Philadelphia, Pa.; Columbia, S.C.; Seattle, Wash.; Atlanta, Ga.; and Albany, N.Y.).

The convergence of computer and communication technologies provide major options in meeting the new societal demands of an aging population.

ITEM 5. DEPARTMENT OF ENERGY

FEBRUARY 16, 1982.

DEAR MR. CHAIRMAN: In response to your letter requesting an update of the Department's activities in 1981 affecting older Americans, I am submitting the following enclosures that describe: (1) Departmental activities in the categories of policy initiatives, energy efficiency programs, information collection and distribution activity, and public participation; (2) research on the biological and physiological aging process.

I am pleased to contribute to the annual review of Federal actions and programs related to older Americans.

Sincerely,

JAMES B. EDWARDS, *Secretary.*

Enclosures.

POLICY INITIATIVES, ENERGY EFFICIENCY PROGRAMS, INFORMATION COLLECTION AND DISTRIBUTION ACTIVITY, AND PUBLIC PARTICIPATION

An overview of DOE's efforts should be considered before a detailed presentation of activity in each of the following categories: Policy initiatives, energy efficiency programs, information collection and distribution activity and public participation. DOE's immediate and long-term objectives are the assurance of adequate, available, and realistically priced energy supplies for all American consumers. DOE is cognizant of and sensitive to the impact of energy cost and supply on moderate and low-income older American households whose incomes are already strained to meet their basic needs.

During 1981, DOE has been aware of the need to address policy and price impact issues on the older consumer and has continued to make efforts to be involved with national organizations and Federal agencies who have been concerned with energy needs of older Americans. Those activities will be addressed in more detail below. Energy conservation, the development of renewable energy sources, utility regulatory reform, energy development impact assistance, and conservation incentives are some of DOE's activities that have had significant implications for older Americans. The following will be descriptions of activities and programs in each of the aforementioned categories:

POLICY INITIATIVES

DOE has continued its effort to actively implement all its statutory responsibilities, especially the National Energy Act. DOE contributed to the development and formulation of policies that have resulted in the passage of the Low-Income Home Energy Assistance Act of 1981.

DOE continued efforts to assure that the energy-related needs for older Americans are equitably met. The following are examples of policy initiatives that have been taken to respond to the issues concerning older Americans.

Energy use and demographic analysis.—One of the supplements to the national energy policy plan (NEPP), entitled interrelationships of energy and the economy, analyzed the differences in energy expenditures between elderly and other households under the assumption that oil prices rise 3 percent above the general rate of inflation. The energy price impacts were forecast for 1990 and included both total energy use and specific fuels such as heating oil, gasoline, and natural gas. In addition, the forecasts were compared with actual 1980 energy use.

The experience of several age groups, including those 55 to 64 and 65 and over, is being examined as part of a study by Data Resources, Inc. (DRI), of the impact of energy inflation on the poor. A novel feature of this study is its focus on estimating the indirect effects of energy price increases with regard to food, shelter, and clothing.

The Office of Conservation and Renewable Energy conducted several studies that dealt with consumer responses to energy requirements and information. One aspect of these studies was the use of behavioral research to help understand consumer responses. As part of this work, analysis was made of different responses from different age groups within the population. The work also considers demographic trends (including the increasing percentage of older people) and their effect on energy use.

Energy assistance programs.—DOE supported the administration's efforts to implement the low-income energy assistance program during the 1980–81 heating season. This program, administered by the Department of Health and Human Services, provided $1.8 billion in assistance to low-income families, with a special emphasis on the needs of the low-income elderly. DOE worked together with a special energy outreach project to better inform the eligible elderly of their opportunity to participate in this program.

Age Discrimination Act activity.—The Office of Equal Opportunity published in the Federal Register on October 6, 1981, the DOE proposed regulations on nondiscrimination on the basis of age, applicable to grant funded programs. The purpose of the proposed regulations is to implement the provisions of the Age Discrimination Act of 1975, as amended, which prohibit discrimination on the basis of age in programs or activities receiving Federal financial assistance. Additionally, DOE personnel policies governing such programs as recruitment, hiring, training, labor relations, and performance appraisal systems prohibit discrimination on the basis of age.

Utility regulatory reform activities.—DOE continued to provide funds under its innovative rates program to four States to conduct 2-year projects to study:

(a) The costs and benefits of lifeline-type rates to low-income consumers of electricity; (b) the type of assistance programs currently available to this class of customers; and, (c) whether a specific low-income rate is appropriate and justified.

The projects are important to the aging to the extent that the aging are among the groups which constitute the low-income population. Retired persons on fixed incomes may find that expenditures for electricity are claiming a larger proportion of their income. These studies review the alternative policies for dealing with this issue.

The studies are scheduled for completion in the fourth quarter of 1982.

Impact of energy prices and policies on socioeconomic groups.—DOE continues to measure and analyze the impacts of energy policies and rising energy price on various socioeconomic groups.

ENERGY EFFICIENCY PROGRAMS

Weatherization assistance program.—The low-income elderly and the handicapped receive priority under this program, which provides grants for the installation of insulation, weatherstripping, storm windows, and other energy-saving measures.

In fiscal year 1981, the weatherization assistance program awarded over $268,363,090 in grants to States and 25 Native American tribal organizations for the weatherization of homes of low-income persons. Reports submitted from the inception of the program through October 1981, indicate that 750,711 low-income homes were weatherized and that the majority of those dwellings were occupied by the elderly. In fiscal year 1981, 291,535 homes have been weatherized.

Residential conservation service.—Implementation of this program by the States began in October 1981. The program requires major utilities to offer energy audits, to offer to arrange for the financing of the purchase and installation of energy conservation measures, and to permit repayment of associated loans through monthly utility billings. The program also requires development of lists of suppliers, contractors, and lenders, and should be useful to the elderly as well as other members of the population. Proposed revisions to these regulations, aimed at reducing associated burdens, were published in the Federal Register.

Institutional conservation program.—Title III of the National Energy Conservation Policy Act provided for a matching grant program to support, among other things, professional analyses of the energy conservation potential in public care facilities. The effect of this program is to identify for building operators ways to conserve energy and thus cut their operating costs. The program also hopes to influence the capital investment decisions of the institution's management.

In fiscal year 1981, the institutional conservation programs division (ICP) conducted the third grant program cycle for programs authorized by title III of the National Energy Conservation Policy Act. During this funding cycle, 96.5 percent of the available funds were obligated. Through fiscal year 1981, ICP has awarded grants for energy conservation projects in over 29,000 buildings, with an average cost per grant of $33,400.

Appliance efficiency program.—During 1981, DOE continued its effort to determine whether minimum energy efficiency standards are needed for 8 of the 13 products covered by this program. The eight products are furnaces, clothes dryers, refrigerators and refrigerator-freezers, freezers, central air-conditioners, room air-conditioners, water heaters, and kitchen ranges and ovens.

INFORMATION COLLECTION AND DISTRIBUTION

The Energy Information Administration, Office of Data Consumption System, collects and publishes comprehensive data on energy consumption in the residential sector through the residential energy consumption survey. This survey includes data collected from individual households and actual billing data from the households' fuel suppliers for a 12-month period. The data include information on energy consumption, expenditures for energy, cost by fuel type, fuel storage, and related housing unit characteristics (such as size, insulation, and major energy-consuming appliances).

In 1981, the Office of Consumption Data System published a major report from this survey that contains data about the elderly. The report "Residential Energy Consumption Survey: 1979–80 Consumption and Expenditures," provides estimates of the cost and amount of electricity, natural gas, fuel oil, kerosene, and liquefied petroleum gas used by all households including those headed by the elderly. It also includes estimates on insulation characteristics of housing units for which the household head is elderly. The report comes in two volumes. Part I contains national estimates, while part II contains estimates for the four census regions. These reports can be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

In 1982, the Energy Information Administration will publish a similar report on consumption for 1980–81. In addition, special studies of the energy consumption patterns of the elderly based on these data are being conducted and will be published in 1982.

PUBLIC PARTICIPATION ACTIVITIES

DOE continued its active participation in the "Energy and Elderly Consortium." The consortium is composed of over 60 organizations from the public sector, private nonprofit sector, and from the energy industry. This organization is the only one of its kind that brings Federal agencies such as DOE and the Administration on Aging together with national aging organizations, and the private industry sector such as the American Gas Association, American Petroleum Institute, Edison Electric Institute, and others, to review and discuss solutions for the energy-related needs of the elderly. Through participation in this group, DOE has exercised leadership in forming partnerships with a variety of organizations that have worked to meet the energy needs of the elderly.

This participation had led to the organization and development of a workshop scheduled in early 1982 to address partnerships and collaborative efforts between the energy industry and the older energy consumer.

DOE was represented on the Intergovernmental Task Force for the 1981 White House Conference on Aging. This activity brought together several activities in DOE to address the policy issues concerning the energy-related needs of older Americans. The Department participated in the 1981 White House Conference on Aging by providing reference materials, resource persons, and public information for the conference delegates.

DOE involved the National Council on Aging in the public hearing process for the development of the national energy policy plan. This activity was to assure that there would be a representative cross section of older Americans participating in the public review process of the plan.

The present administration's philosophy is clearly presented in the 1981 national energy policy plan "Serving America's Energy Future." This national energy plan states in the first chapter the role of the Federal Government and presents the basic principles and guidelines for our energy future. It is as follows: "The Federal Government has one overriding concern in energy during the years ahead. That is to establish sound, stable public policies that will encourage individuals and groups in the private and public sector to produce and use energy resources wisely and efficiently.

"The best guarantee of maintaining a wholesome balance among competing interests in regard to energy lies in allowing the American people themselves to make free and fully informed choices.

"All Americans are involved in making energy policy. When individual choices are made with a maximum of personal understanding and a minimum of governmental restraints, the result is the most appropriate energy policy."

RESEARCH RELATED TO BIOLOGICAL AGING

As in previous years the Office of Health and Environmental Research (OHER) has administered a major program of research aimed at identifying and characterizing the health impacts of energy. In assessing the energy-related health impacts, it is important to identify and chracterize long-term, late-appearing effects induced by chronic exposure to low levels of hazardous chemical and physical agents. Health effects caused by chronic low-level exposure to energy-related toxic agents often develop over the entire lifespan. Consequently, such effects must be clearly distinguished from the normal aging process. To make a valid distinction between chemical toxicity and spontaneously occurring changse, information on pathophysiological changes occurring throughout the lifespan must be collected for both experimental and control (unexposed) groups. These data are obtained primarily from controlled studies in animals and help to characterize the normal aging processes as well as the toxicity of energy-related agents over time. Additional studies are conducted to obtain a better understanding of the aging process itself. Thus, although DOE does not sponsor a specific program of research on aging, two categories of studies related to biological aging were continued during 1981: (a) Studies indirectly concerned with biological changes occurring over long periods of time in animals and in humans, and (b) studies designed to elucidate the biological processes in aging.

As in the past, lifetime studies of humans and animals constitute the major effort in ongoing research related to biological aging. Because of an extensive and long-term involvement in lifetime animal studies, several DOE laboratories contribute information to the Laboratory Animal Data Bank developed by the Battelle Columbus Laboratories under support from the National Library of Medicine and other Federal agencies. DOE laboratories provide data on life histories, pathology, hematology, and clinical chemistry from control animals throughout their lifespan.

As in previous years, research directly concerned with the aging process has been conducted on a limited scale at several of the Department's contractor facilities. Summarized below are specific research projects addressing aging that the Department sponsored in 1981.

LONG-TERM STUDIES OF HUMAN POPULATION

These studies provide valuable data on health effects and life shortening in human populations exposed to hazardous chemical and physical agents associated with the energy technologies. Additional information on lifespan and aging in human populations is also collected. Since logn-term studies of human populations are costly, time-consuming, and complex, they are initiated on a highly selective basis.

The Radiation Effects Research Foundation (RERF), sponsored jointly by the United States and Japan, continued work on a lifetime followup of survivors of atomic bombings that occurred in Hiroshima and Nagasaki in 1945. Over 100,000 persons are under observation in this study.

Detailed clinical and laboratory studies, and morality and autopsy data are collected on irradiated and control populations to identify diseases that have contributed to life shortening among survivors. An important feature is the acquisition of valuable quantitative data on dose-response relationships. Studies specifically concerned with age-related changes are also conducted. It was recently reported that the effects of ionizing radiation on mortality are specific and focal, and principally carcinogenic. No evidence of radiation-induced premature aging has been obtained.

After being accidentally exposed in 1954 to radioactive fallout released during the atmospheric testing of a thermonuclear device, a group of some 200 inhabitants of the Marshall Islands has been followed clinically, along with unexposed controls by medical specialists at the Brookhaven National Laboratory. Thyroid pathology, which has responded well to medical treatment, has been prevalent in individuals heavily exposed to radioiodine. (This study is currently conducted under the auspices of the Department's Office of Operational Safety.)

Nearly 2,000 persons exposed to radium occupationally or for medical reasons have been studied at the Center for Human Radiobiology, Argonne National Laboratory. Individuals in the study receive medical and radiologic (dosimetric) examinations at the center. Work emphasizes the study of persons with relatively low-body burdens of radium. Data on tumor induction by bone-seeking, alpha-emitting radionuclides are being generated. Of importance are quantitative dose-response data for tumorigenesis. The center recently initiated an epidemiologic study of a large worker population occupationally exposed to thorium by inhalation during the period from about 1935 to 1974. This study utilizes vital statistics, employment histories, and records from the Social Security Administration to evaluate health effects of interaally deposited thorium on 100 randomly selected workers. Data on morbidity and mortality are collected. The center is also conducting a followup study in a small group of exposed humans to evaluate late-appearing health effects of plutonium.

At the Los Alamos National Labortory, an epidemiologic study of plutonium workers at six Department of Energy facilities is in progress. An estimated 15,000 to 20,000 workers will be followed in the study of mortality data and at least one-third of these will also be studied by collecting detailed morbidity and personal-history data periodically via questionnaires. Autopsy data are obtained through the U.S. Transuranium Registry (see below). So far there is no excess mortality due to any cause in 224 males with the highest plutonium exposures: A higher than normal incidence of digestive tract cancers in both males and females is likely due to cultural and socio-economic factors; and, 26 males exposed to plutonium during World War II show no evidence yet that adverse effects exist 32 years after exposure.

Some 170,000 contractor employees at Department of Energy facilities are being analyzed in an epidemiologic study to assess health effects produced by long-term exposure to low-levels of ionizing radiation. Workers at the Hanford (Washington) and Oak Ridge (Tennessee) plants, and at the Mound Laboratory (Miamisburg, Ohio), are subjects of the study, which is directed by Oak Ridge Associated Universities (ORAU) with assistance from teams at each of the facilities that house the workers' records and vital statistics. Radiation dosimetry as well as exposures to other toxic agents in the work environment are carefully evaluated.

The U.S. Transuranium Registry, which is operated by the Hanford Environmental Health Foundation, collects occupational data (work, medical, and radiation exposure histories) as well as information on mortality in worker populations exposed to plutonium or other transuranium radioelements. Detailed autopsy data are obtained on workers at the time of death. At the present time, some 14,500 workers from 10 facilities are registered with the foundation. The autopsy data are available for use in other epidemiologic studies such as the ORAU study of radiation workers and the Los Alamos study of plutonium workers. A similar registry of uranium workers was started in 1979.

A study to determine possible relationships between the work environment and worker health is being conducted on 400,000 workers employed at eight shipyards since the early 1950's. Approximately 125,000 of these workers have had exposure to external radiation. The purpose is to identify past and present shipyard employees and to establish an automated record system that incorporates data on individual work histories, types of jobs, radiation exposures, estimatetd exposures to other workplace hazards, and smoking and drinking histories. It is planned to establish the vital status of all workers and cause of death among deceased workers, and to conduct analyses to establish a dose-response relationship between radiation and mortality by cause of death. At this time, employee records at all eight shipyards have been microfilmed and basic data are being abstracted and transferred to magnetic tape.

A lifetime study of humans occupationally exposed to hazardous agents associated with nonnuclear energy technologies has been initiated. This is an epidemiologic study of workers at the Paraho Oil-Shale Retorting Plant located at Anvil Points, Colo. About 100 workers exposed to oil-shale dust and fugitive emissions from the retorting process are being studied to identify possible work-related health effects. The study involves an occupational survey, industrial hygiene survey, and periodic physical examination of workers.

LIFETIME STUDIES IN SHORT-LIVED MAMMALS

Although data from humans are indispensable in the assessment of health impacts associated with any hazardous agent, limitations inherent in human studies make it mandatory to acquire quantitative data from controlled lifetime studies of animal populations. Data from animals significantly enhance predictive capabilities. Data from both short- and long-lived mammals are needed.

Small rodents with lifespans of 2 to 3 years (rats, mice, hamsters) provide data in a minimum of time and at low cost. Consequently, rodents have been used in large-scale studies of late somatic and genetic effects induced by low doses of ionizing radiation. For example, at the Argonne National Laboratory and the Oak Ridge National Laboratory, mice have been exposed to ionizing radiation delivered in different daily increments to characterize radiation-induced diseases and abnormalities that reduce the lifespan. These studies using gamma and neutron radiations have yielded valuable information on dose rate and radiation quality as important factors that modify mammalion response to radiation stress. The study of control (unexposed) populations is providing data on lifespan, morbidity patterns, and causes of death in unstressed animals. Lifetime studies of tumorigenesis and other somatic effects of ionizing radiation in rodent populations are currently being conducted at the Brookhaven National Laboratory, the Lawrence Berkeley Laboratory, the Battelle-Pacific Northwest Laboratory, the Oak Ridge National Laboratory, the University of Utah, the Lovelace Inhalation Toxicology Research Institute, and the University of California, Davis. Included in the ongoing effort are studies involving external sources, neutrons, gamma radiation, and heavy ionizing particles), actinide isotopes that are present in nuclear fuels (plutonium–239, american–241, uranium–233, and others), radium isotopes, and producvts of nuclear fisison (including tritium and krypton–85).

Rodent populations are also used in lifetime studies of health effects associated with exposures to energy-related chemicals. Because many potentially hazardous materials require toxicological evaluation, such studies are conducted as part of a systematic multitiered screening and testing program. The number of ongoing lifetime studies will be increasing as short-term toxicological studies continue to identify additional materials for long-term testing. These studies are now producing data related to chronic disorders including cancer.

Most of the ongoing and lifetime studies of chemical agents address potential health impacts of present-day and advanced fossil-fuel technologies. Two ongoing studies with a generic focus are defining variables that influence tumor induction by polynuclear aromatic hydrocarbons in emissions and effluents from fossil-fuel operations. One is a study at the Brookhaven National Laboratory in which the induction of mammary tumors in rats is under investigation. The other generic study is designed to provide an understanding of processes involved in the multistage induction of rodent skin tumors. A recently concluded lifetime study was performed at the Pacific Northwest Laboratories to understand diseases of the respiratory tract caused by the inhalation of coal dust, diesel-engine exhaust, or combinations of the two. The results are being published this year.

Four studies of health risks associated with coal-combustion technologies are currently in progress. Research at the University of California, Davis, is defining health effects of power effects of powerplant fly ash, in combination with sulfur-containing emissions (sulfur dioxide or sulfates), using rats subjected to long-term exposures by inhalation. This study is to determine functional and morphologic consequences of damage to the respiratory tract. At the Lovelace Inhalation Toxicology Research Institute, lifetime studies of rodents exposed to emissions from conventional and fluidized-bed combustion facilities are in progress. Initial studies are concerned with particulate emissions. Biological end-points being assessed are lifespan shortening, functional disorders, and pathological changes, including carcinogenesis. Two projects at the Pacific Northwest Laboratories are evaluating the chronic toxicity of metals and metal oxides in emisisons and effluents from coal combustion facilities. In these studies, rodents are exposed by ingestion and by inhalation. Emphasis is placed on evaluating iron-deficient and newborn animals as subpopulations sensitive to toxic effects of cadmium.

In related work currently in progress at the Lovelace Inhalation Toxicology Research Institute, carcinogenic, mutagenic and other adverse effects of particulate exhaust emissions from diesel automotive engines are under investigation. The purpose of this study is to evaluate chronic health effects that may be associated with the large-scale use of light-duty diesel vehicles. Included in the ongoing effort is a study of chronic health effects in rodents chronically exposed to diluted diesel-engine exhaust emissions throughout the entire lifespan. A total of 1,800 mice and nearly 1,900 rats are involved in the lifetime study.

A number of lifetime studies are conducted in connection with the conversion of coal to secondary fuels and the extraction of oil from oil shale. Studies are underway to assess the cancer incidence and lifespan reduction caused by exposure to polynuclear aromatic hydrocarbons from coal gasification and liquefaction. Argonne National Laboratory conducts a program on the role of cancer-promoting agents in malignant tumor production in skin, lung, and liver. At the Oak Ridge National Laboratory, lifetime animal studies are comparing skin, lung, and nonspecific cancer caused by compounds in coal liquefaction products. A related project has begun to assess the chronic toxicity of various classes of chemicals in products from coal liquefaction operations. Lifetime studies in rats and hamsters at the University of Connecticut, Farmington, are defining chronic toxicity and carcinogenic risks associated with the ingestion and inhalation of nickel-containing materials in the waste streams of coal gasification facilities. Health risks associated with the solvent refining of coal to a solid fuel (SRC I) and to a liquid fuel (SRC II) are being defined at the Pacific Northwest Laboratories. Here studies of rodents chronically exposed by inhalation or dermal application to components of process streams and fugitive emissions are in progress. At the Los Alamos National Laboratory, ongoing research with rodents is assessing chronic pulmonary toxicity of raw and spent oil shale, evaluating the pulmonary carcinogenicity of crude shale-oil fractions, and defining health effects associated with chronic exposure to retort gases and particulates.

LIFETIME STUDIES WITH LONG-LIVED MAMMALS

From some points of view, long-lived mammalian species represent better human surrogates than do their short-lived counterparts. Thus, obtaining quantitative data on responses of long-lived species to hazardous agents is important. The beagle dog has served for more than 20 years as the long-lived mammal in lifetime radiation-effects studies sponsored by the Department of Energy. Data from beagles faciiltate attempts to interrelate data on animal responses with those on humans. At the Argonne National Laboratory, the University of Utah, the University of California, Davis, the Lovelace Inhalation Toxicology Research Institute, and the Pacific Northwest Laboratories, population of beagles are kept under careful experimental observation. In these lifetime studies, periodic clinical examinations and laboratory analyses are performed on all exposed and control animals, and complete data on gross pathology and histopathology are collected. Accumulated data contain a wealth of information on lifespan, age-related changes, morbidity, mortality, and causes of death in normal animals, as well as alterations in these characteristics that may be induced by radiation. Lifetime studies currently in progress focus primarily on late appearing radiation effects. Included are studies of external radiation (gamma radiation) and internally deposited radionuclides administered by inhalation, ingestion, or injection. All ongoing studies involve careful dosimetric measurements and the acquisition of dose-response data. Because of cost and time, lifetime studies of beagles are initiated on a highly selective basis. No energy-related agent other than ionizing radiation has yet been evaluated via a lifetime study in a long-lived animal. Limited studies of other agents may be undertaken in the future as needs for such studies are identified by short-term testing in other biological systems.

RESEARCH DIRECTLY CONCERNED WITH AGING

The death of George A. Sacher on January 24, 1981, has taken from the Argonne National Laboratory the principal driving force behind the laboratory's longstanding program of research on aging. A review article "Evolutionary Theory in Gerontology," written by Mr. Sacher just before his death is being edited by some of his longtime associates for publication as a memorial to this creative and productive scholar.

Interest in biological aging has continued at the Oak Ridge National Laboratory where progress was made in several areas of research related to the aging process. A study of possible age-related changes in transfer-RNA molecules has been completed.

Contrary to preliminary observations, the weight of evidence now suggests that no consistent age-related changes are detectable using available techniques. This project, which is supported in part by a training grant from the National Institutes of Health, is now directed to the study of albumin molecules and has progressed to the state where it is possible to compare the fidelity of albumin molecules produced by young and by old mice with assurance that results will be free of artifactual heterogeneity.

In this work, albumin is analyzed by a specific antibody reaction, by isoelectric focusing, and by SDS gel electrophoresis. No evidence of age-related changes in the albumin molecule has yet been detected. In another study, Oak Ridge investigators have been conducting experiments with two strains of mice differing significantly with respect to length of lifespan—one has a mean lifespan of over 700 days as opposed to a mean lifespan of only about 450 days in the other—in order to investigate genetic factors underlying aging and longevity. A major difference between the two strains has been found to reside within a cluster of genes known as the "major histo-compatibility complex" (MHC); which is known to regulate functions of the immune system. It is also known that length of lifespan is significantly affected by genetic factors and that aging is associated with marked changes in the MHC. Results of the Oak Ridge study suggest that genes controlling the MHC may ~~also control~~ the aging process. Further research will be needed to test this possibility. In a third study at Oak Ridge, tumorigenic responses to diethylnitrosamine (DEN) were investigated in mice of different ages. When compared with young animals, the aging mice were found to have similar incidences and types of tumors of the same size and in the same tissues. In the aging animals, however, tumors developed after shorter periods of exposure to DEN. It is concluded that age at the time of exposure does not alter the tumor-susceptible tissue or types of tumors induced by DEN treatment, that tumors incidences are not affected by age at time of exposure, and that mice die earlier from induced tumors as age at time of exposure increases.

At the Brookhaven National Laboratory, the relationship between two aging constants—the Gompertz function and the maximum potential lifespan (T)—has been examined for 25 animal species exhibiting considerable difference in patterns of growth. For these species, the product of the two constants (t) was found to be roughly the same (less than an order-of-magnitude overall variation). This finding is interpreted as evidence against the somatic mutation theory of aging and in favor of the view that aging is related to metabolic factors (such as free radical production during respiration). Also at Brookhaven, further research was conducted to explore the possibility that the aging process is affected by cellular capacity for DNA repair. For this purpose experiments were carried out using four types of cell systems: (1) Cells from individuals with premature aging syndromes, (2) cells from old and young animals of the same species, (3) cells of different ages in culture, and (4) cells of the same age but from species with different lifespans. Based on data obtained, there seems to be no causal connection between aging and a decrease in DNA repair. The experiments are "best described as indicating that cells lose the capacity to do effective DNA repair as they age just as they lose the capacity to do many other things."

Research at the Chemical Biodynamics Division, Lawrence Berkeley Laboratory, has explored behavioral responses (shock-motivated passive avoidance task) in young, intermediate-age and old mice to the protein synthesis inhibitor, anisomycin (ANI). Observations made indicate that the retention of older mice is susceptible to disruption by the action of ANI for a longer time after training than normally occurs in young or intermediate age mice. The preliminary interpretation of this finding is that the transition time from short- to long-term memory is longer in older mice than in young mice.

TRENDS AND PROSPECTS

Given the need to assess long-term and late-appearing effects of hazardous agents associated with energy technologies, lifetime studies of animal and human populations will continue. Additional lifetime studies of chemical agents will be needed in the future. Accordingly, more data describing age-related changes should be forthcoming, and a modest program of research on the aging process itself is expected to continue.

ITEM 6. DEPARTMENT OF HEALTH AND HUMAN SERVICES

JANUARY 29, 1982.

DEAR MR. CHAIRMAN: We are pleased to submit the annual reports which you requested from Federal agencies concerning their programs and services for older persons.

The following reports are included with this letter: Administration on Aging; Administration for Native Americans; Title XX; Social Security Administration; Health Care Financing Administration; Alcohol, Drug Abuse, and Mental Health Administration, including National Institute of Mental Health, National Institute of Alcohol Abuse and Alcoholism, National Institute on Drug Abuse; Food and Drug Administration; Health Resources Administration; Health Services Administration; National Institute on Aging; National Institute on Arthritis, Metabolism, and Digestive Diseases; National Cancer Institute; National Heart, Lung, and Blood Institute; Office of the Inspector General; and the Office of the General Counsel.

The above agencies are those which you named in your letter of September 18 to Secretary Schweiker. In addition to these, I am including reports from three other agencies concerning their activities related to the older population; namely, the National Center for Health Statistics, the National Eye Institute, and the National Institute of Neurological and Communicative Disorders. All of these reports are submitted for your consideration for inclusion in Developments in Aging.

If you require further information about these reports, your staff may contact Donald Smith, Director of our Office of Management and Policy Control.

Sincerely,

LENNIE-MARIE P. TOLLIVER, Ph. D.,
Commissioner on Aging.

Enclosures.

OFFICE OF HUMAN DEVELOPMENT SERVICES

ADMINISTRATION ON AGING

REPORT FOR FISCAL YEAR 1981

INTRODUCTION

This report describes the major activities of the Administration on Aging in fiscal year 1981. Title II of the Older Americans Act of 1965 established the Administration on Aging as the principal Federal agency for carrying out the provisions of the act. The provisions of the Older Americans Act are principally concerned with removing barriers to economic and personal independence for older persons and with assuring the availability of appropriate services for those older persons in greatest social and economic need. These provisions are implemented primarily through the establishment of a national network on aging. This network consists principally of the Administration on Aging at the Federal level, and the State agencies and area agencies on aging established under title III of the act at the State and local community levels. In fiscal year 1981, Congress allocated a total of $672,448,000 to support programs and activities to implement the provisions of the Older Americans Act, as amended.

This report is divided into four sections. Section I describes the functions, responsibilities, and interagency activities of the Administration on Aging at the Federal level. Section II provides an overview of the provisions of title III of the Older Americans Act, and summarizes the principal activities of the network of State and area agencies on aging in fiscal year 1981. Section III describes the title VI program of grants to Indian tribal organizations. Section IV presents a summary of AoA's fiscal year 1981 discretionary funding intiatives under title IV, a description of its fiscal year 1981 evaluation program authorized under title II of the act, and a description of the fiscal year 1981 activities conducted under AoA's long-term care program. An appendix at the end of this report contains the listing of all the projects supported by AoA with discretionary funds in fiscal year 1981.

SECTION I. THE ADMINISTRATION ON AGING

ROLE AND FUNCTION OF AOA

The Administration on Aging is located within the Office of Human Development Services in the Department of Health and Human Services. It consists of a central office in Washington, D.C., and 10 regional offices. Title II of the Older Americans Act, as amended, describes the basic roles and functions of AoA. Chief among these are to administer the programs authorized by Congress under titles III, IV, and VI of the act, and to serve as an effective and visible advocate for older persons within the Department and with other agencies and organizations.

The AoA regional offices are responsible for providing direction and guidance to the State agencies on aging funded under title III, and assistance to Governors and other top level State officials in the planning and implementation of policies and programs for older persons. They are responsible for approving title III State plans, as well as for the collection of performance data used in analysing the effectiveness of the title III program. In addition, regional offices administer selected discretionary grants including some model projects and training grants authorized under title IV.

The Administration on Aging central office, in addition to its responsibilities for administering titles III, IV, and VI of the act, plays an active role within the Federal Government on behalf of the aging network and the older population in a variety of ways. AoA provides advice, assistance, and consultation to the Assistant Secretary for Human Development Services, the Secretary of DHHS, other Federal agencies, and to Congress on the characteristics, circumstances, and needs of older persons. It also reviews and comments on departmental policies and regulations regarding community health and social service development.

A major effort by the Administration on Aging at the Federal level has been the development of cooperative arrangements with other agencies to foster the coordination of Federal programs related to the purposes of the Older Americans Act. AoA has entered into several formal interagency agreements to achieve this purpose. These agreements are described below.

INTERAGENCY AGREEMENTS

In fiscal year 1981, AoA actively participated in implementing interagency agreements, including those with the following Federal agencies.

USDA/Farmers Home Administration.—AoA signed an agreement with the FmHA to improve the availability of congregate housing and services to rural older Americans. This agreement was initiated in fiscal year 1979 and continued through fiscal year 1981. FmHA agreed to the construction of congregate housing facilities at 10 demonstration sites. In fiscal year 1981, AoA continued funding support for the provision of social services at these sites.

Health Services Administration.—An agreement was made by AoA in fiscal year 1979 with HSA for the purpose of coordinating existing social and health service delivery systems operated under the auspices of AoA and HSA. In fiscal year 1981, AoA used its discretionary funds to continue support for eight health service demonstrations intiated under this agreement in prior years.

Legal Services Corporation.—In fiscal year 1977, AoA developed a formal agreement with LSC to improve access to legal services for older persons. In fiscal year 1981, AoA produced a report on the legal services program for older persons under title III with the assistance of two staff persons from the Legal Services Corporation. This report was the result of a mandated study required by the 1978 amendments to the Older Americans Act.

Interdepartmental Task Force on Information and Referral.—AoA continued in fiscal year 1981 the operation of an interdepartmental task force on information and referral established through formal agreements with the Departments of Labor, Transportation, Housing and Urban Development, the Veterans Administration, Public Health Service, Social Security Administration, and several other Federal agencies. The task force directs its efforts to assess existing Federal I. & R. resources and develop plans for improving and coordinating these resources on behalf of the older population. Reports have been published for 1978 and 1979 activities. During fiscal year 1981 the report on activities in 1980 was developed and published.

Department of Interior/Heritage Conservation and Recreation Service.—An agreement between AoA and the Department of Interior was made in June 1980 to improve recreational resources and opportunities for older persons. In fiscal year 1981, AoA provided partial financial assistance under this agreement to support an aging component to a national recreational survey.

Department of Transportation.—The purpose of this agreement, which was initiated in 1975, is to increase the mobility of older persons by improving access to public and specialized transportation services in urban and rural areas Activities under this agreement resulted in the establishment during fiscal year 1981 of nationwide special insurance rates for those providing social services to older persons. In fiscal year 1981, AoA and DOT also held a series of meetings to discuss and plan for future legislative initiatives and jointly supported training efforts.

National Endowment for the Arts/National Endowment for the Humanities.—In fiscal year 1981, AoA established a formal agreement with the two Endowments and the White House Conference on Aging. Under this agreement, NEA staff was detailed to the White House Conference on Aging, a policy symposium was conducted at the WHCoA miniconference in Philadelphia, and an interagency task force was established between NEA, NEH, and AoA. During fiscal year 1981 this task force also developed a plan for collaboration between the aging network and the arts and humanities network.

Office of Civil Rights.—In fiscal year 1981, AoA initiated a formal agreement with the Office of Civil Rights to provide technical assistance to State agencies on aging to promote voluntary compliance with the Age Discrimination Act regulations by programs and activities funded by the Department of Health and Human Services. OCR transferred $234,391 to AoA to support a 15-month contract to be monitored jointly with AoA.

National Institute on Aging.—AoA established a formal interagency agreement with NIA in fiscal year 1981 to support the establishment of a national archive for computerized data on aging at the University of Michigan.

National Library of Medicine.—An agreement with the National Library of Medicine was established by AoA in fiscal year 1980. In fiscal year 1981, AoA continued this agreement under which aging information and bibliographies are obtained from the National Library of Medicine for use in AoA's National Clearinghouse on Aging.

Department of Housing and Urban Development.—In fiscal year 1980, AoA entered into an agreement with HUD to fund a contract for an evaluation of the congregate housing program. During fiscal year 1981, AoA and HUD continued support for the evaluation activities under this contract. The project is scheduled to be completed in December 1983.

Veterans Administration.—AoA established an agreement with the VA in fiscal year 1981 to analyze and assess the VA hospital-based home care program. The VA transferred $50,000 to AoA's evaluation program to conduct this project. The agreement will result in information regarding the costs of providing professional services in the home, relate the outcomes of different treatment methods to the costs of those treatments, and determine the type of staff needed to provide such services in a cost-effective way.

Section II. Title III Social and Nutrition Services

A. TITLE III—OVERVIEW

Title III of the Older Americans Act of 1965, as amended, authorizes the provision of formula grants to States to establish agencies on aging at the State and local levels for planning, coordination, resource mobilization, administration, evaluation, and other functions on behalf of the older population. The general purpose of the program is to develop greater capacity at the State and local levels and foster the development of comprehensive and coordinated community-based service systems. The law requires the designation of a unit within State government to carry out the purpose of the Act—the State agency on aging. The State agency is required in turn to subdivide the State into "planning and service" areas and designate for each area an area agency on aging. Funds are available based on approved State and area plans on aging to support the work of operating the agencies on aging and of providing a wide range of social and nutrition services authorized under parts B and C of title III.

Fiscal year 1981 title III activities are based on the implementation of the 1978 amendments to the Older Americans Act. The 1978 amendments required States, and in turn AAA's, to change from an annual to a 3-year planning cycle beginning with fiscal year 1981. These amendments provide States with three separate allocations for title III–B, social services; and title III–C, congregate nutrition services and home-delivered nutrition services. Funds are awarded under title III–B to States and pay up to 85 percent of operating and establishing social services and multipurpose senior centers. State agencies then award these funds to area agencies on aging on the basis of approved area plans and the intra-State funding formula. The 1978 amendments required State agencies to establish and maintain long-term care ombudsman programs at the State level, and required area agencies to spend at least 50 percent of their funds on access services such as transportation, outreach, and information and referral, in-home services such as homemaker and home health aides, and legal services.

Title III–C nutrition service funds are awarded by formula grants to each State agency which then makes awards to area agencies on aging on the basis of State-approved area plans and the State funding formula. The title III–C program funds up to 85 percent of the cost of operating and establishing nutrition services. Area agencies implement this program by making awards to community service providers for congregate as well as home-delivered nutrition services.

In fiscal year 1981, a total of $624,148,000 was appropriated for the title III program. Approximately $251.5 million was allocated to support title III–B social services and senior center activities, $295 million for title III–C congregate nutrition services, and $55 million for title III–C home-delivered nutrition services.

In addition to their titles III–B and III–C service responsibilities, the Older Americans Act charges the State and area agencies on aging to serve as effective and visible advocates for older persons at the State and local community levels. The agencies perform this function by reviewing and commenting on State and community policies and programs as they relate to the needs of older persons, through the coordination of the activities of other agencies as they relate to the purpose of the act, and by drawing down additional resources from other State and community agencies and organizations.

B. STATE AGENCIES ON AGING

There are 57 States and other jurisdictions receiving support under title III of the Older Americans Act, as amended. All States and justifications have approved 3-year plans as required by the 1978 amendments to the act.

State agencies are organizationally located in State governments either as independent agencies reporting directly to the Governor, or as parts of large human services agencies. In fiscal year 1981, there was a total of 1,800 persons on the staff of State agencies, including 162 older persons. States have established a total of 683 planning and service areas throughout the Nation. In fiscal year 1981, States awarded 670 grants to area agencies on aging in the planning and service areas. Thirteen States function as single PSA's.

In fiscal year 1981, States spent an estimated $22,675,000 of title III funds for administrative and other activities. State agencies also obtained an additional $12,209,000 in matching costs from other sources.

States used approximately $4.9 million of title III-B funds to establish and maintain long-term care ombudsman programs as required by the 1978 amendments. These amendments required States to spend 1 percent or $20,000 (whichever is greater) of title III-B funds for these programs. Through the ombudsman programs States have addressed such issues as nursing home regulations, abuse of residents' funds, medicaid discrimination, and restrictions on access to nursing homes by members of the community. State agencies reported in fiscal year 1981, that the important issue of access to nursing homes has generally been secured through the passage of ombudsman enabling legislation or through amendments to State health department licensure regulations.

In addition to their major responsibilities regarding State plan development, the designation of planning and service areas, and the funding of area agencies on aging, State agencies on aging initiate collaborative efforts with other State agencies for system development and coordination of services, initiate proposals for State legislative change to improve the lives of older persons, seek to generate nontitle III resources to carry out the purposes of the Older Americans Act in their State, actively participate in State planning and policy formulation, and implement administrative changes for more effective and efficient management. State agencies have reported a variety of statewide activities and achievements in these areas during fiscal year 1981. A summary of selected examples of these activities and achievements is presented below.

Legislative Improvements

During fiscal year 1981, State agencies on aging actively influenced many State legislative improvements that benefit the older population. The Rhode Island legislature passed two new bills addressing the needs of its older population. House bill 5717 provides $250,000 of State money for an in-home service program for "grey-area" low-income persons who are not eligible for assistance from other programs. Senate bill 305 mandates all persons to report the incidence of elder abuse to the Rhode Island Department of Elder Affairs, which in turn is required to investigate immediately these reports of abuse.

The New Hampshire State Legislature passed three new laws which (a) reduce the eligibility age for the State discount program from 65 to 60, (b) provide a bill of rights for nursing home patients, and (c) require pharmacists to dispense nonbrand name drugs unless a physician specifically prescribes in writing a brand name medication.

During fiscal year 1981, Iowa passed a resident bill of rights for older persons institutionalized in health care facilities. Nebraska passed four new bills which (a) allow school buses to be used for senior transportation, (b) provide for State income tax credit equal to 50 percent of the elderly tax credit allowable under Federal income tax law, (c) provide financial assistance of $300 per month for a family or disabled person living independently whose gross income does not exceed the median family income for a family of four in Nebraska, and (d) exempt small transportation systems from public transportation system rules so that nonprofit organizations may receive State assistance directly rather than through local political subdivisions.

California passed six new pieces of legislation which:

—Establish a durable power of attorney—this protects the elderly, since in the past the power of attorney lasted for 1 year only. For protection, the durable power of attorney can be revoked any time.

—Extend the provinces of the small claims court to provide adivsers for litigants. These advisers are law students from the senior law center.

—Require the Department of Insurance to write medi-gap (insurance over medicare) regulations to come into compliance with Federal law. This will help the elderly against being sold unnecessary insurance.

—Allow that another small unit may be constructed on property usually zoned for a single housing unit, if this unit is occupied by a senior person (60+).

—Set up pilot projects where elderly will share housing with other seniors, or with other families.

—Set up a statewide system whereby all funds which are held by attorneys for their clients during litigation, will be in one interest bearing fund. The interest will serve to fund legal centers for low income and especially senior persons. It is estimated that the interest would be approximately $500,000 per year.

The Texas State Legislature passed five new bills during fiscal year 1981 which:

—Elevate the Texas State Agency on Aging to departmental status known as the Texas Department on Aging.

—Transfer the administration of adult protective services from the Texas Department of Human Resources to the Texas Department of Aging. This bill also granted legislative access to adult protective services worker to unlicensed and licensed facilities and private residences in the State, to investigate abuse cases, age 65 and over.

—Increase the penalty from a class C to a class A misdemeanor and in certain instances to a felony thus resulting in increased penalties for crime committed against the elderly.

—Require any day care facility for the elderly, including retirement villages, to submit an annual report to the Department of Human Resources so that the safety of the facilities can be monitored.

—Provide State sales tax exemptions on items sold for senior citizens fundraising.

Through the efforts of the Maryland Office on Aging a bond program has been initiated which encourages the conversion of public buildings to multipurpose senior centers which to this date has led to over $1 million being allocated for these conversions. The State has passed a number of tax initiatives resulting in lower income and property tax. During the last legislative session, the State created a mechanism which will permit the establishment and regulation of life-care communities.

During fiscal year 1981, the Pennsylvania Department of Aging called for legislation requiring continuing care providers to register with the State before entering into an agreement with clients. Continuing care or life-care facilities provide a home or apartment and services to older persons in exchange for substantial entrance fees paid when a resident occupies a unit, plus monthly maintenance fees. There are some 20 continuing care facilities in Pennsylvania, serving approximately 10,000 older persons. Legislation is currently pending.

The Maine Legislature funded at a level of $1.25 million, a program of in-home and community services to the elderly and disabled for the purpose of preventing inappropriate institutionalization. The same legislature also passed bills to fund additional adult protective service workers who will deal with the statewide elderly abuse problem; and funding for one additional nursing home ombudsman who will investigate complaints made by or on behalf of nursing and boarding home residents.

The Vermont Legislature in 1981, passed an amendment to the State employment statutes eliminating mandatory retirement and adding age and handicapping conditions as reasons for protectinng persons from nondiscrimination in employment. The State Legislature also amended the unemployment statute to allow 50 cents per dollar offset to social security recipients eligible for unemployment insurance. This means that one-half of the income received from social security will be disregarded in figuring unemployment compensation.

New York State passed several legislative initiatives during fiscal year 1981:

—Under New York State's real property tax credit, or "circuit breaker," homeowners and renters aged 65 or older with incomes up to $12,000 (increases to $16,000 for 1982 taxes) are eligible for property tax relief in the form of a refundable income tax credit; or a direct rebate if no income tax is payable, of up to a maximum of $200 per household, for elderly persons with incomes of $7,200 or less (increases to $9,200 for 1982).

—A full passthrough of the Federal SSI cost-of-living increase to recipients became effective July 1, 1981.

—On the county level, elimination of the final 1-percent county sales tax on home heating fuels became effective September 1981.

—Effective January 1, 1982, all pension income up to $20,000 will be excluded from State income tax liability for qualified persons.

New Jersey Legislation passed in July 1981, restricts the evictions of certain senior citizens from residential dwellings when these buildings or mobile home parks are converted to a condominium or cooperative. The "Tenancy Protection Act" grants 40 years tenancy protection for disabled and people 62 years and older as long as they lived in their apartments for 2 years prior to conversion and meet income eligibility criteria.

The Louisiana State Legislature during fiscal year 1981 enacted laws which achieve the following:

—Persons 62 years of age or older are exempt from the payment of an admission charge to any State park in Louisiana; such older persons are also entitled to a reduction in the fee charged for camping privileges.

—Identification cards are to be provided without cost to residents of Louisiana who are 65 years of age or older.

—Elderly, physically handicapped, or mentally handicapped persons are to be given priority, when possible, in the delivery of nonemergency health care services in hospitals owned and/or operated by hospital districts, and in hospitals which receive any financial assistance from the State.

—A $1.5 million appropriation bill for the State's nutrition program earmarks $40,000 for assessing the needs of older persons. An appropriations bill for area agencies on aging increases the $850,000 discretionary fund for services to older persons by an additional $227,000.

A bill of rights for nursing home patients was passed by the Georgia Assembly. The bill protects patients against neglect, abuse, and exploitation. The North Carolina General Assembly enacted a bill, governing the rights of residents in State-defined domiciliary care homes. Persons living in noninstitutional settings, outside of family settings, will have specific rights delineated and enforced. Kentucky is reviewing legislation that will give tax breaks to families that take care of their own members. In the area of consumer representation, South Carolina passed a bill that provides for lay representation and election of nominees for licensing boards, e.g., medical examiners, nurses, etc. In Florida, legislation was passed that allows contributions in the State's community care for the elderly program, thereby increasing the financial resources of the program.

Wisconsin enacted a senior tax option program that gives homeowners aged 65 and older the option of postponing payment of the property tax on their home until ownership of the home changes hands. The Ohio Legislature provided legal immunity to parties who donate perishable foods to charitable/nonprofit community organizations such as congregate meals programs for the elderly. The legislatude has also required that all drug, capsules, or tablets be coded to insure proper identification. Finally, the legislature raised the general and family estate tax exemption from $5,000 to $10,000 and allowed an alternate evaluation of farmland for estate tax purposes.

The Arkansas Legislature appropriated $3 million in State funds to support the State's comprehensive in-home services program. Arkansas Area Agencies were approved by medicaid in January 1980, as providers of in-home services and they currently receive approximately $7 million yearly in funds from all sources for in-home services provided. The Oklahoma legislature appropriated $500,000 for the development of three long-term care channeling models in the State.

Arizona completely revised its nursing home regulations during fiscal year 1981. The major feature of the legislation is the establishment of a standardized method for determination of patient acuity. A proposal being considered currently by the legislature would bring a modified form of medicaid into the State for the first time.

Hawaii's revised statutes charge the State office on aging with the responsibility of representing the interests of residents of long-term care facilities, individually and as a class, and with promoting improvements in the quality of care received and the quality of life experienced by these residents.

In August 1981, a bill was passed by the Oregon State Legislature and signed into law which established a State long-term care ombudsman program with local designees and provided access to facilities. Legislation was also passed granting residents of long-term care facilities or their legal guardians the right to inspect their medical records.

The New Mexico State Agency on Aging achieved significant results during the 1981 New Mexico legislative session. The passage of the senior citizens capital outlay bill appropriates $750,000 to the aging network to upgrade senior centers in meeting fire and safety code regulations and to renovate and/or replace transportation vehicles used for aging activities. The Crime Victims Reparation Act was enacted into law, with an appropriation of $1,800,000 for the purpose of protecting citizens of New Mexico from the impact of crime and to promote a stronger criminal justice system. Senate Joint Memorial, State Board Appointments of Elderly, provides for proportional representation of elderly citizens on State and local boards, commissions, and advisory groups.

Administrative Improvements

During fiscal year 1981, State agencies on aging engaged in a variety of activities for making improvements in their administrative capacity. Several examples are presented below.

The Bureau of Maine's Elderly developed a client-oriented system for prioritizing and targeting critical services to older persons in order to improve the quality and efficiency of service delivery in the State.

The New Jersey Division on Aging designed an evaluation instrument for use in assessing area agencies on aging by measuring their capacity to develop and administer their area plans and to be the focal point for the elderly in their geographic planning areas.

During 1981, New Jersey State modified its PSST system (program summary system tracking) to obtain more accurate information on a statewide basis to inform how and what programs are being provided. In addition, they are preparing for the new 1982 legislature a handbook which describes all programs and related statistics by legislative district.

In 1981, the Alaska State Legislature created the Alaska Commission on Aging which is responsible for planning and administration of programs for the elderly. The commission was made a part of the department of administration which also administers the Alaska longevity bonus program, a program of payments to elderly citizens who have resided in the State since statehood; and the Alaska Pioneer Homes, a network of State-funded nursing homes and homes for the aged. The consolidation of Older Americans Act programs and State-funded programs for the elderly reflect Alaska's continuing efforts to improve the administration of programs for the elderly.

The Ohio Commission on Aging is developing a management information system for use by all area agencies in the State to standardize reporting activities. The system will also incorporate statewide and local data bases describing the demographic and health characteristics of older persons in Ohio.

The Illinois Department on Aging established a new division of administrative compliance to develop and implement an administrative procedure review. This review will examine the performance of area agencies and service providers with regard to financial and program compliance issues.

Washington's State Unit on Aging, formerly known as the bureau of aging, was expanded through reorganization of the State's department of social and health services and has become the bureau of aging and adult services. New programs added to the bureau are chore services, adult protective services, congregate care facilities, adult family homes, community nurses, and residential placement. The reorganization makes the bureau of aging and adult services responsible for the administration of a comprehensive array of services to the elderly and enhances coordination of aging programs.

In Flordia, the State agency, in conjunction with the department of health and rehabilitative services office, has revised the overall manual for fiscal management requirements for OAA recipients. The State unit on aging is also realining its functional responsibilities in order to improve the administration of aging and adult services programs.

In Arizona, the aging and adult administration developed a model program and reporting system in response to the findings of the HHS auditors. As a result of the system, Arizona now gets monthly expenditure and program information which is current, accurate, and complete.

Pennsylvania's Governor created a cabinet-level human resources committee to coordinate the State's administration of social programs and to prepare implementation plans for the block grant approach to funding social programs. An executive order creating the human resources committee specified that it is designed "to deal with human resources issues and projects which require interdepartmental action." "Services for the elderly" was identified as a specific category for block grants and the Pennsylvania Department of Aging was designated as the lead agency to coordinate the program.

In fiscal year 1981, the Iowa Commission on Aging automated their management information system for greater program effectiveness and control. The computerized system receives, analyzes, and issues feedback management reports to AAA's that measure the AAA's progress made during the year as correlated with goals and objectives stated in the AAA area plan.

Planning and Coordination

During fiscal year 1981, State agencies were active in improving the planning and coordination of services, service systems, and other resources on behalf of older persons. The following are examples of these activities.

The New York State Office for the Aging represents the interests of older New Yorkers on such major interagency policy forums as the health planning commission, the crime control planning board, the rural affairs council, and the State council on housing and community development.

The New York State office provides staff support on a continuing basis to various State-level task forces, including the weatherization policy advisory committee, the State department of social services' home heating task force, the office of health systems management/PSRO acute care hospital backlog committee, and the Governor's health advisory council task force in informal supports.

The New York State office also has assisted in the development and implementation of the department of social services' enriched housing program, the department of state's community development technical assistance program, the State energy assistance program, and the Chautauqua County congregate housing demonstration program.

Westchester County Office for the Aging, New York, developed a network of planning area councils, made up of municipal officials and representatives from clubs, centers, and agencies which deal with services and issues relevant to seniors. The role of the planning area council, is to review data on assessment of needs, services, and priorities, to conduct local meetings on the findings, to develop local recommendations for services, and to advocate for new services at the appropriate local level.

Florida conducted a statewide team-building workshop that included the entire aging network throughout the State. The objective was to improve communication and working relationships among attendees in order to improve long-range service delivery.

In Mississippi, the State IRS and aging agencies have jointly developed a tax counseling and form preparation assistance program for the elderly.

The Pennsylvania Department of Aging and the Department of Education entered into an agreement to coordinate educational opportunities for the elderly. The agreement calls for greater use of community educational facilities including school lunchrooms, recreational areas, and transportation systems to encourage and help meet educational needs of senior citizens. The departments of aging and education also will be working together to effect legislation to provide the elderly with better access to educational facilities in their community.

The Washington Bureau of Aging and Adult Services is part of a planning reform demonstration project (consolidated State plan) combining the plans for nine State social-service agencies receiving funds through HHS grants. Coordinated planning and administration of the separate but related services are expected to result in improved delivery and reduced paperwork, as well as more effective use of Federal and State funds.

The D.C. Office on Aging assisted the housing board of the National Caucus and Center on Black Aged in developing service programs at NCBA's new 175 elderly housing unit in downtown Washington. The State office has also assisted in the management of several other elderly housing complexes in the planning of social services and programs.

Program and Service System Development

State agencies on aging engaged in a variety of activities during fiscal year 1981 to enhance program and service system development and to obtain additional State resources, and to provide information to older persons and the community on the problems of the aging.

The Lincoln, Nebr., Area Agency on Aging and the Nebraska Commission on Aging proceeded with the development of a 5-year community systems development project funded by the Robert Woods Johnson Foundation. The project has a strong medical orientation and is focusing on hospital discharge planning. The commission is also supporting the AoA-funded technical assistance group community development project with the Beatrice, Nebr., AAA.

The Iowa Commission on Aging and the Area VIII Agency on Aging in Dubuque began development of a community service system in the Dubuque area. The system will focus on individual assessment, case management, and coordination of existing services for affected clients. Technical assistance to the AAA is provided by the commission and the University of Iowa Gerontology Project.

The Connecticut Department on Aging initiated in fiscal year 1981 the development of a statewide elderly home care system when it requested the executive director of Triage, Inc., to help create Connecticut Community Care, Inc. The purpose of CCCI is to administer the State's five home care projects. It is a private nonprofit coordination, assessment, and monitoring agency whose board is composed of leading representatives of the aging network, private industry and older citizens.

The Michigan Office of Services to the Aging and the Public Health Department's Office of Substance Abuse jointly established five substance abuse finding and treatment centers throughout the State. These centers serve the elderly by helping them solve alcohol and drug abuse problems.

In Delaware, the State division on aging and other State officials coordinated with the Nemours Foundation in the establishment of a health clinic which provides both dental and eyeglass service to low-income elderly. Three million dollar will be spent on this program annually.

Vermont has undertaken two new programs in fiscal year 1981 funded by ACTION. The Vermont Office on Aging is the grantee for a model rural senior companion program with home-based orientation. The program serves 9 of the 13 counties of the State. The regional administrative functions are being provided by three area agencies and three RSVP projects.

The Vermont Office on Aging is also the grantee for a VISTA project in which three VISTA's were placed in State job service offices to assist older persons in finding employment.

The State of Maryland initiated a number of innovative programs in fiscal year 1981. The first of these is the sheltered housing program which provides subsidized housing and some personal care services for those elderly no longer capable of living alone.

Under the public guardianship program the Maryland Office on Aging is appointed the guardian of last resort for medical and fiscal decisions.

Another major initiative in Maryland is the family support demonstration project which provides cash supplements to families caring for their elderly relatives. There are approximately 150 families enrolled in this project.

South Carolina began a "lifeline" project in fiscal year 1981. This is a personal emergency response system that provides immediate 24-hour access to community medical and social services at the press of a button attached to crisis telephone.

Kentucky, through volunteers, is developing a "share and care" program where the elderly track domestic skills for such things as home repair.

North Carolina's Division of Aging has developed a statewide program for maintaining and improving the physical health of older adults. The anagram for the program is "AHOY," add health to our years.

The District of Columbia Office on Aging obtained funds in fiscal year 1981, to purchase, renovate, and operate the Washington Center for Aging Services which began admitting residents needing skilled nursing care and intermediate care in November 1980. The center will serve as the focal point of a long-term care system, and brings into being a public/private partnership between the District of Columbia Government and a consortium of four universities—Georgetown, Howard, George Washington, and Catholic.

Arizona has developed a statewide system of ombudsman using adult protective services workers. APS workers have warrant authority to enter any premises (residential or institutional) accompanied by a law enforcement official to investigate suspected instances of abuse and neglect.

With approximately $200,000 in Administration on Aging funds during fiscal year 1981, and State agency assistance, San Bernardino County Area Agency on Aging generated $750,000 in local support. This was made possible by the foundation of local regional councils on aging with nonprofit status which enhanced the community's ability to attract resources from local groups that wished to make tax deductible donations to senior programs. Donations have been obtained from local businesses such as savings and loan associations and supermarkets to support senior center renovation, transportation, and a discount food purchasing program.

In Tennessee, the private bar association, in conjunction with a title *III* funded legal services program, established a pro-bono panel to provide legal services as a result of a cutback in the Legal Services Corporation funds. Each attorney on the panel has agreed to accept up to three cases per year of elderly clients.

The Pennsylvania Department of Aging received a $25,000 grant in fiscal year 1981 from the Sun Co., Radnor, Pa., to fund a series of six public television programs on aging topics and to pay the expenses of some older persons attending the Pennsylvania White House Conference on Aging which was held in March 1981. The shows were aired by four of Pennsylvania's seven public broadcasting stations and covered a variety of topics including transportation and the rural elderly; prescription drugs and quackery; fraud; special problems of being old, poor, and black; housing; and the role religion plays in the lives of older persons.

The department of aging also implemented a plan to improve employment opportunities for older Pennsylvanians. The program is entitled "Project Harvest" (hiring the aging reaps vitality, experience, stability, and talent). The harvest theme was chosen to emphasize the point that mature citizens are a rich resource which society must learn to utilize fully rather than discard prematurely. The program is aimed at improving the quality of life for the 1.5 million Pennsylvanians of retirement age by offering better and more diversified opportunities for meaningful employment and improving preparation for those who choose to retire.

Older riders on the Metropolitan Boston Transportation System can now take advantage of a special free fare program between 9:30 a.m. and 4:00 p.m. The fare at all other times is one-half the regular fare. The free fare is in effect on all bus, subway, and commuter trains. It was developed through the cooperative efforts of the Governor, DEA, and the Secretary of Transportation.

In fiscal year 1981, the Massachusetts State Legislature allotted an additional $17 million for the low-income home energy assistance program. Assistance depends on income and the type of heating fuel used. The program also includes low-cost energy conservation services.

The advisory committee on elder occupational education and training was established in April 1981. It is comprised of members from the private and public sector. Its purpose is to identify job market needs and to focus on the education and training required for identified opportunities.

Massachusetts appropriated $2 million of State funds for an elderly nutrition program which is operated in conjunction with the title III–C nutrition program.

C. AREA AGENCIES ON AGING

In fiscal year 1981, there were 670 area agencies on aging operating under title III of the Older Americans Act as compared to 602 agencies in fiscal year 1980. An area agency on aging may be a public or private body, an Indian tribe, or a sub-State regional body. Area agencies have the major responsibility for the administration of funds for title III–B social services, and title III–C nutrition services. Area agencies receive their funds from the State agency on aging and award grants and contracts to local social and nutrition service providers under an approved area plan. Area agencies are responsible for providing technical assistance and monitoring the effectiveness and efficiency of the service providers they fund. Through their additional functions of coordination and planning, these agencies serve as the focal point for the concerns of older persons at the community level throughout their planning and service areas. Area agencies interact with other local public and private agencies and organizations in order to coordinate their activities and draw down additional resources to be used on behalf of the older population.

In fiscal year 1981, there was a total of 9,400 persons on the staffs of area agencies, including 2,350 older persons. The staffs are augmented by approximately 37,000 volunteers through the Nation.

Area agencies received an estimated total of $580,990,400 of title III funds during fiscal year 1981. Approximately $35.5 million were spent for administrative purposes. Area agencies tapped other community sources for an estimated $266,500,000 to augment the title III funding.

Area agencies spent approximately $222,790,000 for title III–B services during fiscal year 1981. Area agencies were required by the 1978 amendments to spend at least 50 percent of their title III services funds for access, in-home and legal services. In fiscal year 1981 agencies spent an estimated $91,344,064 on such access services as transportation, escort, outreach, and information and referral. In-home services such as homemaker and home health aid, visiting and telephone reassurance, and chore maintenance were supported with approximately $42,301,170. Area agencies spent an estimated $13,367,244 to provide legal services for older persons. An estimated $75,777,336 supported other community and neighborhood services such as residential repair, alteration, and renovation of facilities to serve as multipurpose senior centers, health services, physical fitness program, and preretirement and second career counseling services. The total number of older persons served in fiscal year 1981 by these services is estimated at 9 million persons. This includes approximately 1,710,000 minority (19 percent), and 5,670,000 (63 percent) low-income older persons.

Area agencies on aging spent an estimated total of $322,700,000 for title III–C nutrition services in fiscal year 1981. Approximately $258,160,000 supported the congregate nutrition programs, and $64,540,000 were spent for the home-delivered nutrition services. The nutrition services programs served an estimated 175 million meals during fiscal year 1981, at an average cost of $3.05 per meal, to approximately 3 million older persons. This included an estimated 1,920,000 low income, and 810,000 minority older persons. Title III–C nutrition services were provided by approximately 1,200 nutrition projects at 13,000 established nutrition sites throughout the country.

SECTION III. TITLE VI GRANTS TO INDIAN TRIBES

In fiscal year 1981, the Administration on Aging continued the title VI program authorized by the Older Americans Act, as amended. AoA initiated this program in fiscal year 1980. The purpose of this title is to promote the delivery of social services, including nutritional services for Indians that are comparable to services provided under title III by State and area agencies on aging. The title VI program allows Indian tribes to apply to the Administration on Aging for direct Federal funding. AoA works closely with the Administration for Native Americans to coordinate the activities and provision of social services to Indians by other Federal agencies.

There are four categories of services mandated under title VI of the Older Americans Act. Nutrition services either in a congregate setting or as home-delivered meals must be provided which meet the religious and cultural dietary needs of Indians age 60 or over. Legal services must be provided by organizations which can insure that Indians whose language is other than English have access to legal counsel when the need arises. Grants under title VI require the establishment of information and referral services designed to provide information to older Indians on the available services to meet their special needs and to provide the necessary assistance to them so that they can take full advantage o. those services and opportunities.

Finally, if there is a long-term care facility in the service area that is subject to the jurisdiction of the tribe, the tribal organizations receiving title VI grants must establish a viable ombudsman program with the capacity to investigate and resolve problems and complaints by older Indians residing in long-term care facilities, and to provide information both to the tribal organizations and the Commissioner on Aging about the problems of Indians residing in such facilities. Title VI funds may also be used for other services necessary for the well-being of older Indians, including water services, road clearing, fuel, temporary shelter, and the construction, alteration, or renovation of facilities to be used as multipurpose Indian senior centers. Funds may be used for staffing such centers as well.

In fiscal year 1981, 84 Indian tribal organizations continued to receive a total of $6 million under title VI, serving an estimated 15,902 older Indians. During this fiscal year, AoA developed and implemented a system for program monitoring and financial reporting that parallels that used in title III. AoA also administered a contract funded under its title IV–A education and training program to provide training and technical assistance to the 84 tribal organizations for the administration of their grants.

SECTION IV. AoA DISCRETIONARY PROGRAMS

INTRODUCTION

Title IV of the Older Americans Act, as amended authorizes a program of discretionary grants and contracts to support training and education, research, and demonstration project activities. The purpose of these activities is to develop the necessary knowledge and information base to assist the Administration on Aging and the State and area agencies on aging to carry out the provisions and requirements and achieve the goals and objectives of the act. This section describes the AoA funding activities during fiscal year 1981 for title IV, part A—education and training, part B—research, part C—discretionary projects and programs (or model projects), and part E—multipurpose centers of gerontology. This section also includes a description of the activity regarding the major long-term care initiatives undertaken by AoA in fiscal year 1981, as well as the program evaluation efforts undertaken as authorized under title II of the Older Americans Act, as amended.

In fiscal year 1981, there were $40,800,000 appropriated for the conduct of activities under title IV, $6,654,614 for long-term care, and $309,550 for evaluation.

A. TITLE IV–A EDUCATION AND TRAINING PROGRAMS

Title IV–A of the Older Americans Act authorizes the award of grants or contracts to support a variety of education and training programs for persons who are employed or are preparing for employment in the field of aging. The Administration on Aging spent a total of $13,909,821 on education and training in fiscal year 1981. These funds were used to support projects in seven distinct programs:

—National continuing education and training programs.
—National conference program.
—Regional education and training program.
—State education and training program.
—Gerontology career preparation program.
—Minority research associate program.
—Minority intern program.

Only one new project, the minority intern program, was initiated in fiscal year 1981 in the amount of $349,946.

The rest of the projects receiving awards were to continue efforts begun in previous years. A brief description of each program is presented below.

National Continuing Education and Training Program.—This is a multiyear national training and technical assistance program designed to improve the capacity of State and area agency staff: Training projects funded under this program emphasize improvement of services provided through Older Americans Act. Twelve projects received continuation funding under this program in fiscal year 1981.

National Conference Program.—This program supports workshops, symposia, and conferences for the development and dissemination of information considering the social, economic, political, scientific, and technological policies relating to aging issues. Participants generally include policymakers, business and labor leaders, scientists, educators, service providers, and practitioners. AoA made 10 awards under this program in fiscal year 1981 to continue previously funded projects.

Regional Education and Training Program.—The purpose of the awards made under this program is to assist in the planning and provision of training, technical assistance, and conference activities in a coordinated way among State and area agencies on aging, service providers, and higher education institutions. Projects supported under this program are designed to bring together representatives of these groups to promote training and education activities around common interest areas and to meet common regional needs, to develop inventories of education and training resources in a region, to act as a regional clearing-house for disseminating education, training, and technical assistance materials in the field of aging, and to assess regional education and training needs of current personnel in State nad area agencies, local service provider organizations, and individual practitioners serving older persons. Each of the 10 AoA regions receive support under this program.

State Education and Training Program.—This program awards title IV–A funds to State agencies on aging to support training and technical assistance to improve the knowledge, skills, and performance of State, area agency, and service provider staff, and to promote inter- and intra-State activities which bring together the resources of agencies and organizations concerned with education and training in the field of aging. AoA continued support of State agencies in fiscal year 1981.

Gerontology Career Preparation Program.—This program supports the development and implementation of long-term specialized training programs in post-secondary educational institutions. Funds awarded under this program support universitywide projects, graduate and professional school programs, 2- and 4-year undergraduate projects and consortia projects. Eighty awards were made in fiscal year 1981 to continue projects funded in prior years.

Minority Research Associate Program.—The purpose of this program is to strengthen the participation of minority postdoctoral scientists and faculty in the field of aging and service-related research. AoA refunded five institutions of higher education in fiscal year 1981 to continue this program.

Minority Intern Program.—The purpose of this program is to increase recruitment, training, and placement of minority individuals in order to enhance the number of qualified minority personnel in the field of aging. In fiscal year 1981, AoA awarded funds to initiate the National Center and Caucus on Black Aged the project under this program. The purpose of this award ($349,976) is to recruit and place minority interns in State and area agencies on aging for training in administrative positions. In fiscal year 1981, these funds provided internships for 23 minority professionals in eight State agencies and 15 area agencies.

B. TITLE IV–B, RESEARCH AND DEVELOPMENT

Title IV–B, research and development authorizes funds to study the patterns and living conditions of older persons, to develop or demonstrate new methods for coordinating services, and to collect and disseminate research findings and related information for application in the field of aging. The Administration on Aging's research program has as its primary focus the generation of knowledge and information for policymakers, program managers, and practitioners. In fiscal year 1981, a total of $3,563,783 was available to support research projects. AoA used $2,830,448 to continue 24 projects funded in prior years, and $569,631 to initiate 9 new projects.

Fiscal Year 1981 Continuation Projects

Previously funded projects which received continuing support in fiscal year 1981 encompass the following topical areas:

Health Care, Social and Community-Based Services.—Projects in this area emphasize the improvement of the quality and the effectiveness of the delivery of health and social services to older persons. Issues addressed by projects in this area include the demand and use of health and social services, eligibility and administrative policies that affect accessibility, quality, delivery, and coordination of services, and the impact of legislation on health care and social services for older persons.

Older People, Families and the Community.—Projects in this area focus on developing information concerning the characteristics and needs of older persons, and the way needs are met through family, neighbors, community groups such as churches and synagogues, and other informal support systems. Projects in this area emphasize the development of self-help approaches for addressing the problems of older persons.

Employment, Retirement, and Income.—Projects in this area focus on issues concerned with full participation of older persons in the labor force, involuntary retirement, the transition from work to retirement, and problems encountered by older persons in obtaining employment. Projects also focus on attitudes and behavior of older persons and the consequences of organizational practices and statutory provisions relating to work, retirement, and income.

Housing and Living Arrangements.—Projects in this area are concerned with developing information on the housing and living arrangement needs of older persons. Projects emphasize such issues as the effect of community revitalization efforts on older persons, the impact of policies regarding housing choices of older persons, and the changing characteristics of retirement communities and effects on the older population.

Special Projects.—In addition to research in the above categories, AoA has supported special projects to improve the planning and utilization of research activities, such as research conferences and workshops.

Fiscal Year 1981 New Projects

In fiscal year 1981, AoA developed its research activity to encourage the synthesis of existing information in aging related to the following three broad themes:

The Impact of Aging on Society.—This theme investigates the impact of demographic changes, as well as changes in social institutions, values and societal conditions for addressing individual and group needs through public policy approaches.

The Elderly as a Resource.—This theme is concerned with determining ways in which older persons can serve as providers of formal and informal support for their own peers, and for younger persons, and in other ways act as economic and social resources within society.

Services to Facilitate the Well-Being of Older Persons.—This theme is concerned with developing knowledge that will provide practitioners with a range of options and strategies for the more effective and efficient use of existing resources in the provision of needed services for older persons. It also supports projects which focus on ways in which various services can be linked and integrated in such a manner as to improve the cost/effect ratio as well as assuring that comprehensive, coordinated service systems are available.

The AoA research projects initiated in fiscal year 1981 focus on a variety of issues concerning: Work and retirement among black women; need and service demands of minority older populations; variations among minority populations in approaches to solving problems; the impact of female labor force participation on the care of chronically ill and impaired older persons; environmental hazards and the incidents of accidents among older persons; types of social services required to achieve successful home care results; the development of urban models for the coordination of services; option for a national tax policy to encourage the care of older persons by families and friends in noninstitutional settings; and private pension plan coverage among black and Hispanic workers.

C. Title IV–C Discretionary Projects and Programs

Title IV–C authorizes the award of grants or contracts to support model projects which demonstrate methods to improve or expand social services or nutrition services, or in other ways promote the well-being and independence of older persons. The program seeks to test and demonstrate new mechanisms, systems, or approaches for providing and delivering services that can be used promptly, effectively, and efficiently. The program also seeks to improve the coordination and quality of social and other services for older persons, and to facilitate the exchange of information to stimulate improved approaches, and to assist in the national use of project findings. AoA spent a total of $10,049,933 in fiscal year 1981 to support new demonstration projects, and to continue projects funded in prior years.

Fiscal Year 1981 New Projects

In fiscal year 1981, AoA awarded funds to initiate projects in five areas of priority emphasizing capacity building efforts among State and area agencies on aging and service providers in areas critical to the functioning of older persons. AoA spent a total of $1,819,142 for these new awards in the following categories:

Dissemination and Utilization—Fiscal year 1981 awards were made to demonstrate methods for disseminating and utilizing current knowledge and best practices. Two projects were funded to collect, synthesize, and organize available data from projects funded within the past 5 years concerning informal supports, and to develop model information and referral systems.

Management.—In fiscal year 1978 AoA initiated an effort to strengthen the capacities of the State and area agencies on aging in the areas of information management and organizational capability. In fiscal year 1981 AoA continued this effort by funding five new demonstration projects concerned with building information management systems, and data collection and reporting systems. Another new award was made to improve the organizational capacity of area agencies on aging by examining and isolating those factors associated with their institutional strengthens and weaknesses.

Employment.—In fiscal year 1981, AoA made two new awards to identify and develop employment opportunities for older persons. One project is developing and demonstrating a model for small business employer education which concentrates on the value of the older worker as a unique labor resource. The other project is designed to encourage collaboration among business and industry, labor, education, and government in the development of a plan of action for promoting employment opportunities for older workers.

Mental Health.—One new project was funded in fiscal year 1981 to improve the quality of mental health services delivered to older persons. This priority area focuses on the development of effective collaboration among members of the aging network and State and community mental health agencies. The purpose of the fiscal year 1981 award is to facilitate the ability of State policymakers and officials to coordinate their planning, to affect health systems to be more responsive to the special needs of older persons.

Public Policy Options.—In fiscal year 1981, AoA initiated a new priority area designed to define and develop public policy options as alternative approaches to responding to social and individual problems and needs. AoA made six new awards in fiscal year 1981 which address increasing State and area agencies on aging capacity to develop and implement public policy options, developing and strengthening church-based mutual support networks for black elderly, the hospital's role in providing services for older persons, and improving the planning formula used for targeting resources to older persons in greatest economic or social need.

Fiscal Year 1981 Continuation Projects

In fiscal year 1981, AoA spent $5,875,038 to continue support for 30 projects funded in previous years under the following categories:

National Aging Organizations.—Projects in this category are designed to promote a better partnership between AoA, national aging organizations, and the aging network to improve capacity to plan for and deliver services to underserved older persons. Ten organizations received continued support in fiscal year 1981—four which represent minority populations exclusively, and six which represent the older population in general.

State Data Reporting Systems.—Projects in this area foster the development of State systems for improving data collection, storage, reporting, and computerization. Five awards were made in fiscal year 1981 to continue projects funded in previous years.

Services in Rural Areas.—In fiscal year 1981, AoA continued support for five projects in this area. These are designed to demonstrate models for effective linkages, joint planning, and coordination with other local institutions, and organizations. Projects show how a rural area agency on aging can perform a catalytic role in the community and how those agencies can obtain commitment and support to carry out enhanced activities with public and private organizations and agencies.

Elderly Abuse.—Projects in this area are concerned with determining the extent of elderly abuse, the mechanisms for treatment and prevention and exploring ways in which traditional protective services can be enhanced and coordinated with other social services in order to provide services for all elderly who are at risk of being abused. AoA continued three projects in fiscal year 1981 which address these issues.

Services to Minorities.—Projects funded in this area focus on the capacity of area agencies to serve minority older populations. They are designed to improve the appropriateness of services for minorities and to eliminate barriers between service providers and clients. AoA supported four projects in fiscal year 1981 which address these issues.

Enhancement of Services to Migrants, Refugees, and Immigrants.—The purpose of projects funded in this area is to enhance the quality of services delivered to older migrant, refugee, immigrant, and asylee populations by area agencies located in PSA's with a high incidence of such populations. Two projects continued to receive support in fiscal year 1981.

Hispanic Access to Services.—Four projects received AoA funding in fiscal year 1981 in keeping with an Office of Human Development Services initiative aimed at improving access for Hispanic older persons to HDS funded services. Four specific issues are addressed by these projects—employment, information and referral, training, and economic and resource development.

D. TITLE IV–E MULTIDISCIPLINARY CENTERS OF GERONTOLOGY

In fiscal year 1981, the Administration on Aging continued to support six national aging policy centers which were originally funded in fiscal year 1980. The purpose of these centers is to engage in policy analysis and policy research directed toward major policy issues in the field of aging. AoA spent a total of $1,249,244 in fiscal year 1981 to support the six centers.

The policy centers engage in multidisciplinary activities designed toward knowledge building and application, manpower development, and the development of educational program materials within each center's specified issue area. The six issue areas addressed by these centers are as follows:

The Policy Center on Income Maintenance is located at Brandeis University. Some of the major issues addressed by this center include the adequacy of inflation adjustment in pensions, the economic deprivation of older women, the implications of disability policy for older age, and the impact of changes in social security policy on retirement income.

The Policy Center on Education, Leisure and Continuing Opportunities for Older People is located at the National Council on Aging. This center is addressing the fundamental policy question of how America's expanding population of older persons can be mobilized as a growing national resource rather than perceived as a problem and burden in society. Some of the policy-related issues in this area include the educational system and the aging society, voluntary action and older adults, and leisure, culture and lifespan development.

The Health Policy Study Center is located at the University of California, San Francisco. Policy issues concerning health include the value of exercise for older persons, nutrition education, State adjustments in medicaid and title XX programs, and State policy influences on residential care facility supply.

The Policy Center on Women and Aging is located at the University of Maryland. This center focuses its attention on issues deriving from the changing demographic and socioeconomic status of older women in American society.

The Policy Center on Housing and Living Arrangements for Older Americans is located at the University of Michigan. This center addresses the housing needs of the older population, alternative housing forms, and the availability of private sector resources as they pertain to adequate living arrangements for older persons.

The Policy Center on Employment and Retirement is located at the University of Southern California. Issues addressed at this center include the future structure of employment opportunities for older persons, employer costs in the development of policies to extend work-life for older persons, and the negative versus the positive incentives for later retirement.

E. LONG-TERM CARE

AoA's long-term care program initiatives derive their authorization from title II, section 202(b) which assigns to the Administration on Aging the responsibility to develop planning linkages with health systems agencies, and to participate in departmental and interdepartmental activities which concern issues of institutional and noninstitutional long-term health care services development. The 1978 amendments to the act give additional impetus to the expansion of AoA's long-term care activities under title III, sections 301(a)(3) and 307(12)(A), and title IV sections 404(a), 441 and 442. In fiscal year 1981 AoA spent a total of $6,654,614 to initiate new projects and continue projects funded in prior years in long-term care.

The long-term care program initiatives of AoA support the improvement of policies, programs, and systems which enhance the opportunity for functionally impaired older persons to secure and maintain maximum independence and self-sufficiency. The mission addresses basic goals of the Department—to serve those *most* in need—as well as the goals of AoA—to insure that services or other appropriate assistance is available to those persons in need.

The purpose of the long-term care initiatives is to develop more effective and less costly solutions for problems resulting from a rapidly increasing functionally impaired older population and escalating costs for health care, personal care and social services which currently already exceed the means of public resources. These initiatives support the title III program of State and area agencies in planning, coordinating, and managing service approaches to the problems of the most vulnerable of the elderly.

The long-term care initiatives address three interrelated objectives: Policy and program development, knowledge building, and capacity building.

The objective of policy and program development defines activities related to knowledge building and increasing the capacity of State and area agencies. The objective of knowledge building supports activities related to policy and program development as well as information dissemination and technical assistance to the network. The objective of capacity building defines a set of activities directed to meeting information and technical assistance needs.

The Administration on Aging's long-term care activities are organized under the following five program components.

Long-Term Care Policy Analysis and Dissemination

One set of activities is the review and analysis of long-term care policies and the dissemination of knowledge concerning these policies. Under a cooperative agreement, the National Conference on Social Welfare and its subcontractor, the Center for the Study of Social Policy, is responsible to AoA for developing and communicating knowledge about long-term care policies to State and local agencies and other selected audiences. The project spans October 1, 1980 to March 31, 1982, and is budgeted at $340,000.

National Long-Term Care Initiative

This departmental initiative, which directly involves ASPE/HCFA/AoA, is aimed at developing a knowledge base drawn from research studies and demonstration projects as a basis for policy and program development and capacity building at the State and local levels. It is comprised of the following interrelated components:

(1) *Long-Term Care Data Base:* (a) analysis and synthesis of existing LTC data; (b) development of methodologies for carrying out future national surveys to determine the incidence and extent of functional impairment among adults, and need, demand, and utiliation of health care, personal care and social services.

(2) *System Developments:* Development of a LTC planning structure at the State level and of a LTC plan based on assessment of needs and resources.

(3) *Channeling Demonstration:* Development of organization structures and operating procedures at the community level to match resources with identified needs, provide technical assistance in the implementation of the demonstrations, and evaluation of process and outcome.

AoA supported this initiative with $9.3 million in fiscal year 1980 and with $4 million in fiscal year 1981.

Long-Term Care Gerontology Centers

By mobilizing the resources of the universities and collaboration with community-based public and private sector agencies the following programmatic activities are undertaken:

(1) Development and evaluation of models of care on a continuum of need.

(2) Development of professional and paraprofessional staff for the delivery of health care, personal care and services through career and continued education and training.

(3) Development of policy, applied and clinical research to improve conditions for the functionally impaired elderly.

(4) Information dissemination and technical assistance to State and local public and private agencies.

Through directed interdisciplinary as well as disciplinary research, education service activities involving a range of expertise represented by university faculty and agency planners, managers and practitioners, these centers will develop a critical mass to assist their local community, State, and region in developing and implementing more cost effective and efficient LTC policies, programs and systems.

In fiscal year 1980, five centers were established with awards totaling $2.125 million. In fiscal year 1981, four additional centers were established with awards in the amount of $1.7 million.

Geriatric Fellowships

To develop a faculty capability for orienting medical students to geriatrics and gerontology, AoA has made awards to six institutions for each to support two fellows for a period of 2 years over a 3-year period.

In fiscal year 1980, AoA supported this program with $585,000; the next scheduled funding is in fiscal year 1982 at an estimated level of $465,000.

Demonstrations

A major thrust of AoA's long-term care activities is to develop community planning and service capacities to meet the needs of chronically ill and functionally impaired older people. The AoA/HSA demonstration projects which utilize primary heatlh care facilities as model service delivery points for vulnerable older persons, and the long-term care model projects which demonstrate the effectiveness of services ranging along a continuum of care, are major efforts directed to this objective. Fiscal year 1980 project costs were $2,616,000. In fiscal year 1981, these demonstrations were supported in the amount of $1,512,000.

F. EVALUATION

The Administration on Aging's evaluation program for fiscal year 1981 involves the continuation of three currently active projects that were funded in prior years and financing one new project with fiscal year 1981 funds. The following is a brief description of these evaluation activities:

Longitudinal Evaluation of the Nutrition Program

This effort was begun in fiscal year 1976, following implementation of the title VII national nutrition program for older persons. This project is a national, longitudinal study of nutrition services under title III of the act. The major purposes of the study are—(a) to assess the effects of nutrition services on program participants; (b) to accumulate information about the operations, activities, and environments of selected nutrition projects and meal sites; (c) to identify program characteristics and other factors that may influence the composition of the participant population, the frequency of their participation and accrued benefits; and (d) to measure changes and trends in such effects on participants as dietary status, isolation, and independent living.

Analysis of Food Service Delivery Systems Used to Provide Nutrition Services

Initiated in fiscal year 1979, this project grew out of the first wave findings of the longitudinal nutrition study. The study is intended to determine the unit costs of providing meals to older persons in congregate settings and in their own homes and to account for the variation in costs through an analysis of such factors as type of food service system and vendor, urban/rural location of projects and meal sites and food quality.

Evaluation of Differences in Needs and Service Programs Between the Rural and Urban Elderly

First funded in fiscal year 1980, this two-phased project was initiated in response to a 1978 statutory mandate that the Administration on Aging conduct a study of the differences in unit costs, service delivery and access to services between urban and rural areas. Completion of the first phase resulted in a February 1981 report to the Congress on the needs of the rural elderly and available service programs. The report covered problems in defining the concept "rural," demographic characteristics of the rural elderly, the comparative economic, physical, psychological, and social status of the rural and urban elderly, and the relative costs of providing services in rural and urban areas. The second phase of the study is directed toward obtaining baseline data on service unit costs, characteristics of service delivery and the relative access of the rural and urban elderly to services.

Evaluation of State Education and Training Program

This is the only evaluation project initiated in fiscal year 1981, funded at a level of $173,000. It is an evaluability assessment of the State education and training program financed under title IV–A of the Older Americans Act. The objectives of this study are to provide, in a systematic fashion, successive increments of information on the State education and training program potential and program performance; to define the State education and training program activities, objectives, its managers' and policymakers' information needs and priorities, and determine how the program is performing in terms of agreed-upon objectives and performance indicators; and to provide alternate designs for performance evaluation if the program performance information collected during this study indicates that additional information is needed and is likely to be useful.

APPENDIX

TITLE IV-A TRAINING
Gerontology Career Preparation Program

Continuation Projects

Title	Recipient	FY 1981 Funds
Region I		
Training for Policy and Management Careers in Aging	Brandeis University, Waltham, Mass.	$ 91,170
Career Enhancement in Mental Health Work with the Aged	University of Bridgeport, Bridgeport, Conn.	$ 26,734
Training Program to Train Social Work Students for Career in Aging	University of Connecticut, West Hartford, Conn.	$ 65,515
Development for Careers in Gerontology	University of Massachusetts, Worcester, Mass.	$129,964
Specialized Career Training in Aging	University of Rhode Island, Kingston, R.I.	$ 74,826
Gerontology Career Preparation	Springfield Technical Community College, Springfield, Mass.	$ 60,198
Region II		
Specialized Career Training Projects	Rutgers University, New Brunswick, N.J.	$102,119
Gerontology Career Preparation	St. Thomas Aquinas College, Sparkill, New York	$ 58,532

TITLE IV-A TRAINING
Gerontology Career Preparation Program

Continuation Projects

Title	Recipient	FY 1981 Funds
Medical Training in Geriatrics and Gerontology - A Decol Approach	New York University, New York, New York	$ 21,859
Cultural/Social Approach to Health Care Needs of the Aging Individual and Family in the Inner City	Medgar Evers College of CUNY, New York, New York	$109,011
Gerontology Career Preparation	College of St. Elizabeth, Convent Station, New Jersey	$ 31,861
Gerontology Career Preparation	Hunter College, New York, New York	$109,011
Gerontology Career Preparation	Syracuse University, Syracuse, N.Y.	$111,788
Gerontology Aide Program	Union College, Cranford, New Jersey	$ 10,624
Development of Career Training in Gerontology for Minority Group Students	Rockland Community College, Suffern, N.Y.	$ 35,136
Multi-Faceted Program in Rural Gerontology	North Country Community College, Saranac Lake, N.Y.	$ 62,020

TITLE IV-A TRAINING
Gerontology Career Preparation Program

Continuation Projects

Title	Recipient	FY 1981 Funds
Region III		
Capacity Building for Minority Institutions in Geriatrics and Gerontology	National Center on Black Aged Washington, D.C.	$135,783
Multidisciplinary Training for Specialized Careers in Aging Services	Pennsylvania State University, University Park, Penn.	$101,296
Physical Therapy Training to Care for the Vulnerable Elderly: An Operational Model	University of Maryland, School of Medicine, Baltimore, MD.	$ 71,259
Gerontology Career Preparation	Southside VA Community College, Alberta, VA.	$ 24,080
Gerontology Career Preparation Program	University of Pennsylvania Philadelphia, PA.	$ 98,003
Gerontology Career Preparation	University of Maryland, College Park, MD.	$107,225
Specialization in Aging Administration	University of Maryland, College Park, MD.	$ 81,978
Gerontology Career Preparation	Virginia Commonwealth University, Richmond, VA.	$ 99,819

TITLE IV-A TRAINING
Gerontology Career Preparation Program

Continuation Projects

Title	Recipient	FY 1981 Funds
Gerontology Career Preparation	Virginia Union University, Richmond, VA.	$ 62,595
Service Providers Legal Training	George Washington University, Washington, D.C.	$ 86,852
Gerontology Career Preparation	Temple University, Philadelphia, PA.	$ 92,311
Multidisciplinary Gerontology Career Training in the Rural Setting	West Virginia University, Morgantown, West Virginia	$ 73,774
Multidisciplinary Undergraduate and Graduate Career Training	University of the District of Columbia, Washington, D.C.	$ 98,939
Gerontology Career Preparation	Norfolk State University, Norfolk, VA.	$ 72,975
Region IV		
Graduate Master of Arts Program in Gerontology	Fisk University, Nashville, Tenn.	$ 78,454
Multidisciplinary Preparation for Careers in Geriatric Care	Duke University, Durham, N.C.	$103,817
University-wide Degree Program in Human Services/Aging	Memphis State University, Memphis Tenn.	$ 26,448

TITLE IV-A TRAINING
Gerontology Career Preparation Program

Continuation Projects

Title	Recipient	FY 1981 Funds
Title IV-A Gerontology Career Preparation Program	LeMoyne - Owen College, Memphis, Tenn.	$ 28,362
Career Preparation for Human Services Practitioners in Gerontology	Nashville, Tenn.	$ 30,901
Certificate in Gerontology	Tougaloo College, Tougaloo, Miss.	$ 47,756
Geriatric Technician Training Program	Wayne Community College, Goldsboro, N.C.	$ 69,889
Gerontology Career Development Program	Tusculusa College, Greensville, Tenn.	$ 39,772
Career Preparation Program in Gerontology	University of Alabama, University, Ala.	$ 93,707
Faculty to Faculty Training and Monitoring Systems	University of Alabama-Birmingham/Jackson State University/Alabama Center for Higher Education, Birmingham, Ala.	$128,001
Focusing on Training for Careers in Services to the Frail and Vulnerable Elderly	University of Florida, Gainesville, Fla.	$78,006
Training Program in Gerontological Clinical Psychology	University of Miami, Coral Gables, Fla.	$ 55,965

4

TITLE IV-A TRAINING
Gerontology Career Preparation Program

Continuation Projects

Title	Recipient	FY 1981 Funds
Career Training for Community Services Administrators in Gerontology	University of South Florida, Tampa, Fla.	$ 77,351
Clark College Gerontology Training Project	Clark College, Atlanta, Ga.	$ 22,171
Community Gerontology Specialists Training	Georgia State University, Atlanta, Ga.	$109,440
Career Training in Aging for Social Planning and Helping Professions	Murray State University, Murray, Ky.	$ 37,268
Region V		
Gerontology Career Preparation Program	Northwestern University, Evanston, Ill.	$ 38,803
Multiple Career Tracks for Working with Older Americans	Miami University, Oxford, Ohio	$ 96,928
Gerontology Career Preparation Program	Ohio University, Athen, Ohio	$ 84,850
Gerontology Programs	University of Michigan, Ann Arbor, Mich.	$123,173
Gerontology Career Preparation Project	Wayne State University, Detroit, Mich.	$129,765

TITLE IV-A TRAINING
Gerontology Career Preparation Program

Continuation Projects

Title	Recipient	FY 1981 Funds
Flexible Multidisciplinary Training Program in Aging at Undergraduate Level	College of St. Scholastcia, Duluth, Minn.	$ 57,673
Activity Therapy in Gerontology Programs	Madonna College, Livonia, Mich.	$ 57,673
Gerontology Career Preparation Program	Metropolitan Community College, Minneapolis, Minn.	$ 72,091
Services for the Rural Elderly	University of Minnesota, Technical College, Waseca, Minn.	$ 34,221
Region VI		
Training Elderly Minorities as Paralegals and Minority Law Students to Serve Elderly Minority Rural People	University of New Mexico, School of Law, Albuquerque, N.M.	$ 98,715
Undergraduate Education for Persons Projected to Work in AoA Supported Stimulated Areas of Aging	The University of Texas Health Science Center at Dallas School of Allied Health Science, Dallas, TX.	$ 54,703
Career Preparation in Aging	University-wide Project, North Texas State University, Denton, TX.	$ 96,063
Training of Personnel in Service Delivery to the Mexican-American Elderly	University of Texas at Arlington, Arlington, TX.	$106,503

TITLE IV-A TRAINING
Gerontology Career Preparation Program

Continuation Projects

Title	Recipient	FY 1981 Funds
Gerontology Career Preparation Program for BA Level Social Workers and Other Professionals Working with the Aged	Paul Quinn College, Waco, TX.	$ 19,809
Multidisciplinary Undergraduate Career Training Program Specializing in Rural Gerontology	Prairie View A&M University, Prairie View, TX.	$ 49,085
Gerontology Career Preparation Program	Saint Edward's University, Austin, TX.	$ 53,919
Aging Studies Career Training Grant	Southern University in New Orleans, New Orleans, LA.	$ 93,459
Multidisciplinary Training Program in Gerontology	University of Arkansas, Pine Bluff, Ark.	$ 51,057
Region VII		
Kansas Consortium for Training in Aging	University of Kansas/Kansas State University, Lawrence, Kansas	$130,513
Gerontology Career Preparation Program	University of Missouri/Joint Centers for Aging Studies, Columbia, Missouri	$ 80,203
Special Career Preparation Program in Gerontology for Allied Health for Professionals	University of Nebraska, Lincoln, Neb.	$ 85,939

TITLE IV-A TRAINING
Gerontology Career Preparation Program

Continuation Projects

Title	Recipient	FY 1981 Funds
A University-wide Career Preparation Program in Aging	Wichita State University, Wichita, Kansas	$ 70,993
Region VIII		
Integrated Ceriatric/Gerontology Curriculum in the Health Sciences	University of Utah, Salt Lake City, Utah	$ 69,072
A Training Program in Vocational/ Occupational Career Education	Weber State College, Ogden, Utah	$ 55,184
Region IX		
Gerontology Career Preparation	University of Hawaii, Honolulu, Ha.	$146,433
Gerontology Career Preparation	University of Southern California, Los Angeles, CA.	$ 93,600
Model Gerontological Training for Rural Areas	Northeastern California Higher Education Council, Chico, CA.	$115,000
Long Term Care Administration Program	University of Arizona, Department of Public Administration, Tucson, AZ.	$ 71,516
Gerontology Carrer Preparation Project	University of California, School of Social Welfare, Berkeley Campus Research Office, Berkeley, CA.	$ 97,539
Career Preparation with an Emphasis on Serving the Minority Elderly	San Diego State University, San Diego, CA.	$105,707

TITLE IV-A TRAINING
Gerontology Career Preparation Program

Continuation Projects

Title	Recipient	FY 1981 Funds
Training Program in Multidisciplinary Applied Gerontology	University of California, San Francisco Medical Anthropology Program, San Francisco, CA.	$104,058
Region X		
Title IV-A Gerontology Career Preparation Program	Oregon State University Program on Gerontology, Corvallis, Oregon	$114,288
Gerontology Career Preparation Program	University of Oregon, Center for Gerontology, Eugene, Oregon	$101,249
Interdisciplinary Gerontology Training Program	University of Washington, Seattle, Wash.	$118,057

TITLE IV-A TRAINING
Regional Education and Training Program

Continuation Projects

Title	Recipient	FY 1981 Funds
Region I	John Snow Public Health Group 141 Tremont Street Boston, Mass.	$131,145
II	Kirschner Associates S. 1101 175 5th Ave. New York, New York 10010	$139,087
III	Temple University Sponsored Project Admin. 406 University Service Bldg.	$104,950
IV	Kirschner Associates Suite 816 41 Marietta St., N.W. Atlanta, Ga. 30333	$138,401
V	Kirschner Associates 2 North Riverside Plaza Chicago, Ill. 60602	$151,799
VI	North Texas State University Center for Aging Studies Denton, Texas	$146,219
VII	University of Kansas Gerontology Center 211 Fraser Hall Lawrence, KA. 66045	$147,896

TITLE IV-A TRAINING
Regional Education and Training Program

Continuation Projects

Title	Recipient	FY 1981 Funds
Region VIII	Development Associates 1649 Downing Street Denver, Colorado 80218	$119,329
IX	Western Gerontological Society 785 Market Street Suite 1114 San Francisco, CA. 94103	$133,073
X	Kirschner Associates 1321 3rd Avenue Room 713 Seattle, Wash. 98101	$150,472

TITLE IV-A TRAINING
National Conference Program

Continuation Projects

Title	Recipient	FY 1981 Funds
Issue Development and Conference Program on Key Issues Affecting the Elderly Poor	National Council of Senior Citizens, Washington, D.C.	$ 34,339
SRI International Mini-White House Conference	SRI International, Menlo, CA.	$ 20,000
Strengthening Community Based Long Term Care for Individuals	American Association of Homes for the Aging, Washington, D.C.	$ 35,000
Self Help for Hard of Hearing - White House Conference on Aging Mini-Conference of Elderly Hearing Impaired	Self Help for Hard of Hearing People, Inc., Bethesda, MD.	$ 17,000
Gray Panther Project Fund - Media Conference	Gray Panther Project Fund Philadelphia, PA.	$ 29,992
Navajo Tribal Conference on Aging	Navajo Nation, Window Rock, AZ.	$ 2,500
Senior Centers and Community Focal Point Staff Capacity Building	NCOA, Washington, D.C.	$ 10,692
Brookdale Center - Foundation Conference	Brookdale Center on Gerontology Hunter College, New York	$ 20,000
National Senior Citizens Law Center - Legal Services for the Elderly	NSCLC, Wasington, D.C.	$ 4,000
NVOILA WHCoA Mini-Conference on Public/Voluntary Collaboration		$ 34,754
State Education and Training Program		$4,241,644

TITLE IV-A TRAINING
Continuing Education and Training Program

Continuation Projects

Title	Recipient	FY 1981 Funds
Continuing Education for Area Agencies on Aging	National Association of Area Agencies on Aging	$ 50,000
Orientation of Aging Service Personnel to the Older Americans Act	National Association of State Units on Aging	$123,000
Staff Capacity Building Project for Senior Centers and Community Focal Points	National Council on the Aging	$180,000
Educating Service Providers on How to Respond Effectively to Older Americans adversely affected by Crime	The National Council of Senior Citizens	$ 39,968
Developing Training Models for Community Service Delivery for Care of the Aged	Washington School of Psychiatry	$110,000
Effective Patient Techniques for Use with the Aging Patient	University of Kentucky Research Foundation	$116,000
EQUIP Older Adults: Education for Qualitative Understanding in Programs for Older Adults	CEMREL, Inc.	$ 79,339
Capacitating Personnel for Implementing Community Long-Term Care Systems: Training the trainers Workshop	University of Iowa Iowa Geriatric Center	$ 55,246

TITLE IV-A TRAINING
Continuing Education and Training Program

Continuation Projects

Title	Recipient	FY 1981 Funds
Health Promotion with the Elderly	University of Washington, School of Social Work	$ 85,000
	ACKO, Inc.	$238,792
T&TA on Improving the Management and Fiscal Control of Food Service Delivery System	Community Nutrition Institute	$134,900

TITLE IV-A TRAINING
Minority Research Associate Program

Continuation Projects

Title	Recipient	FY 1981 Funds
Minority Research Associate Program in Hispanic Aging	North Texas State University, Denton, TX.	$ 54,800
Minority Research Associate Program	San Diego State University, San Diego, CA.	$ 74,899
Minority Research Associate Program	Syracuse University, Syracuse, N.Y.	$ 46,520
Social Science Scholars in Minority Gerontology	Miami University, Oxford, Ohio	$ 67,710
Minority Research Associate Program	State University of New York at Buffalo, Buffalo, N.Y.	$ 69,983

TITLE IV-A TRAINING
Minority Intern Program
New

Title	Recipient	FY 1981 Funds
The National Caucus and Center on Black Aged	Washington, D.C.	$349,976

TITLE IV-B RESEARCH
Health Care, Social and Community Based Service

FY 1981 Continuations

Title	Recipient	FY 1981 Funds
Study of the Virginia Nursing Home Pre-Admission Screening Program	Virginia Commonwealth University, Richmond, VA.	$ 58,882
Advocacy in Minority Communities: The Impact of Minority Organization on Resource Allocation	California State University, Sacramento, CA.	$104,132
The Extent of Area Agency Commitment to Minority Older Persons and Strategies for Increasing the Quantity and Quality of Services	Community Research Applications, New York, N.Y.	$ 78,729
Paths to Alternative Service Modalities and Differential Impact of Three Modalities on Similar Groups of Vulnerable Elderly	Hebrew Rehabilitation Center for Aged, Boston, MA.	$174,521
Aging as a Rural Phenomenon	Health Systems Agency of Northeastern New York, Albany, N.Y.	$ 71,754
On Lok Community Care Organization for Dependent Older Adults	San Francisco, CA.	$191,074

TITLE IV-B RESEARCH
Older People, Families and Community

FY 1981 Continuations

Title	Recipient	FY 1981 Funds
The Effects on Families of Caring for Impaired Elderly in Residence	Benjamin Rose Institute, Cleveland, OH.	$131,081
Hispanic Support Systems and the Chronically Ill Older Hispanic	Asociacion Nacional Pro Personas Mayores, Los Angeles, CA.	$ 74,875
A Youth Support System for the Frail Elderly	University of Southern California, Los Angeles, CA.	$ 88,549
Demonstration of a Self-Help Approach to the Coordination of Human and Health Services	Dartmouth College, Hanover, N.H.	$120,925
Self-Help and Advocacy for the Underserved Elderly	University of California, San Francisco, CA.	$ 35,918
Uses in Self-Help and Mutual Aid in Compensating for Sensory Changes in Old Age	American Foundation for the Blind, New York, N.Y.	$ 78,826

TITLE IV-B RESEARCH
Employment, Retirement, and Income

FY 1981 Continuations

Title	Recipient	FY 1981 Funds
Home Equity Conversion Project	Wisconsin State Dept. of Health and Social Services, Madison, WI.	$103,188
The Older Job Seeker: Barriers and Supports in the Job Search	Hunter College, New York, N.Y.	$ 49,851

TITLE IV-B RESEARCH
Housing and Living Arrangements

FY 1981 Continuations

Title	Recipient	FY 1981 Funds
Changing Properties of Retirement Communities	University of Michigan, Ann Arbor, MI.	$189,114
Analysis of Factors Influencing the Housing Choices of Older Persons	Bryn Mawr College, Bryn Mawr, PA.	$ 93,261
What is the Effect of Community Revitalization Efforts on Older Persons	Urban Institute, Washington, D.C.	$104,054
Determinants of Housing Choice Among Elderly: Policy Implications	Massachusetts Institute of Technology, Cambridge, MA.	$156,185
Changing Service Needs of Older Tenants	Philadelphia Geriatric Center, Philadelphia, PA.	$172,452

TITLE IV-B RESEARCH
Special Projects

FY 1981 Continuations

Title	Recipient	FY 1981 Funds
Technological Transfers for the Aging	Population Resource Center, New York, N.Y.	$ 34,582
Fiscal Crisis and Tax Revolt: Impact on Aging Services	University of California, San Francisco, CA.	$ 82,379
Supporting Facilities for Research and Policy Development and Evaluation in the Field of Aging	University of Michigan, Ann Arbor, MI	$251,952
Continuum of Long-Term Care: Health Care of the Elderly: Research Fellowship Program	Gerontological Society, Washington, D.C.	$113,525
Gerontological Research Institute	American Institute for Research, Washington, D.C.	$270,639

TITLE IV-B RESEARCH

FY 1981 New Projects

Title	Recipient	FY 1981 Funds
Work and Retirement: Aging Black Women	University of Michigan, Ann Arbor, MI.	$ 54,973
Differential Characteristics and Rates of Growth of Minority Sub-Populations: Projections of Need and Service Demands Over Time	Community Research Applications, New York, N.Y.	$ 74,731
Problematic Life Situations: Cross-Cultural Variation in Support Mobilization Among the Elderly	Portland State University, Portland, OR.	$ 73,069
Commitment to Caregiving: The Consequences for Aged Family Members and for Governmental Services of Women Working	Hunter College Jointly with the Research Foundation of C.U.N.Y., New York, N.Y.	$ 69,467
Aging and Accidents	Buffalo Organization for Social and Technological Innovations, Buffalo, N.Y.	$ 71,146
Predictors of Successful Home Care Plans	University of Rochester, Rochester, N.Y.	$ 75,000
A Feasibility Study of Two Urban Models	New York City Dept. for Aging, New York, N.Y.	$ 51,747

TITLE IV-B RESEARCH

FY 1981 New Projects

Title	Recipient	FY 1981 Funds
Options for a National Tax Credit Policy to Encourage Noninstitutional Long-Term Care for the Elderly	National Opinion Research Center, Chicago, ILL.	$ 24,560
Policies Affecting the Income Adequacy of the Black and Hispanic Elderly	Brandeis University, Waltham, MA.	$ 74,938

TITLE IV-C MODEL PROJECTS
Dissemination and Utilization

New Awards

Title	Recipient	FY 1981 Funds
Dissemination and Utilization of Research and Demonstration Projects Through Networking	National Council on Aging	$124,913
Study of Model Information and Referral Systems	Alliance of Information and Referral Services, Columbus, Ohio	$ 70,060

TITLE IV-C MODEL PROJECTS
Management

New Awards

Title	Recipient	FY 1981 Funds
Comprehensive and Coordinated Service Delivery in the State of Florida	State of Florida, Department of Health and Rehabilitation Services	$ 85,000
Development of a Statewide System for the Collection of Service Delivery Data at the Point of Delivery	New York State, Office of Aging	$ 83,147
Arkansas Aging Information System	Arkansas, Office on Aging, Little Rock, Ark.	$ 85,000
Three Level Service Data Taxonomy Implementation	State of Texas, Department on Aging	$ 71,387
Phase III: Statewide Client Tracking, Unit Cost	New Jersey, Department of Community Affairs	$ 85,000
Strategies for Capacity Building for the Aging Network	Fordham University, School of Social Sciences	$ 71,093

TITLE IV-C MODEL PROJECTS
Employment

New Awards

Title	Recipient	FY 1981 Funds
Small Business Employer Education	American Management Association	$189,304
National Older Workers Implementation Network: Promoting Employment After 55	University of Michigan	$ 44,966

TITLE IV-C MODEL PROJECTS
Mental Health
New Awards

Title	Recipient	FY 1981 Funds
Mental Health and Aging Systems Coordination Project	Department of Social and Health Services, Olympia, Wash.	$180,000

TITLE IV-C MODEL PROJECTS
Public Policy Options

New Awards

Title	Recipient	FY 1981 Funds
Nonservice Approaches to Problems of the Aged	SRI International	$229,976
Church Based Program to Help the Frail, Black Elder	University of the District of Columbia, Institute of Gerontology	$120,750
Serving Older Americans in Greatest Need	Bureau of Social Science Research, Washington, D.C.	$100,828
Nonservice Approaches to Problems of the Aged: Defining the Role of Counties	National Association of Counties Research, Inc., Washington, D.C.	$ 85,315
The Hospital's Role in Caring for Older Persons: Promoting Integration of Health and Social Services	Hospital Research and Education Trust, Chicago, Ill.	$109,473
Nonservice Approach to Meeting the Needs of the Elderly	Conference of Mayors Research and Education Foundation, Washington, D.C.	$ 84,990

TITLE IV-C MODEL PROJECTS
Legal Services

New Awards

Title	Recipient	FY 1981 Funds
Model Volunteer Protective Services Project.	NRTA-ARRP	$153,000
Enhancing Role of State Aging Networks in Providing Protective Services	University of Southern Maine, Human Service Development Institute	$235,431
National Project to Support and Assist Representation of Older Americans	National Senior Citizens Law Center	$150,000
National Bar Activation Project for the Elderly Project	American Bar Association	$ 85,003

TITLE IV-C MODEL PROJECTS
National Impact

Continuations

Title	Recipient	FY 1981 Funds
National Aging Organization Projects Program	The National Center on Black Aged Washington, D.C.	$349,857
NASU National Aging Organization Project	National Association State Units on Aging, Washington, D.C.	$395,777
	National Indian Council on Aging	$336,398
	National Pacific Asian Elderly Resource Center Special Service for Groups	$313,359
	Asociacion Nacional Pro Personas Mayores, Los Angeles, CA.	$349,052
	National Association of Counties, Washington, D.C.	$119,779
	National Council on Aging Washington, D.C.	$ 96,010
	Western Gerontological Society	$150,000
	United Neighborhood Centers of America	$ 99,954
	U.S. Conference of Mayors	$181,733
	Urban Elderly Coalition	$162,920

TITLE IV-C MODEL PROJECTS
State Data Reporting Systems

Continuations

Title	Recipient	FY 1981 Funds
Model Statewide Service Data Reporting System	State of Connecticut, Dept. of Aging	$125,475
Texas Management Information System Project	State of Texas, Dept. of Aging	$ 52,650
Ohio Aging Services Information System	State of Ohio, Commission on Aging	$ 85,240
An Integrated Statewide Information System for Aging Services in New York	New York State Office for Aging	$ 85,015
Service Data Reporting System	Jefferson County, Alabama Office of Senior Citizens Activity	$ 97,494

TITLE IV-C MODEL PROJECTS
Services in Rural Areas

Continuations

Title	Recipient	FY 1981 Funds
Community Support Systems for Rural Frail Elderly	Mon Valley Health and Welfare Council, Monessem, PA.	$ 83,447
Rural Western Wisconsin Service Delivery System	Area Agency on Aging, Inc., District V, LaCrosse, Wisc.	$ 83,000
Rural Day Care for Elders	Illinois Dept. on Aging, Springifled, Ill.	$ 75,355
Focus on Elderly Health and Social Services for Rural Elderly	Gateway Area Development District, Owingsville, KY.	$ 47,523
Rural Aging Services Project	New York State Office for Aging Albany, N.Y.	$ 83,488

TITLE IV-C MODEL PROJECTS
Elderly Abuse

Continuations

Title	Recipient	FY 1981 Funds
Massachusetts Elder Abuse Project	Commonwealth of Massachusetts, Dept. of Elder Affairs	$125,000
Demonstration Project on Elderly Abuse	Metropolitan Commission on Aging of Syracuse and Onandago County, N.Y.	$ 66,335
Elder Abuse Program	Rhode Island Dept. of Elderly Affairs	$ 54,489

TITLE IV-C MODEL PROJECTS
Enhancement of Services to Migrants, Refugees, and Immigrants

Continuations

Title	Recipient	FY 1981 Funds
Pacific Asian Elderly Service Development Project	Seattle King County Division on Aging, Seattle, Wash.	$118,213
Model to Provide Medical Care and Social Services for Immigrant Elderly	Denver Regional Council of Governments	$ 60,000

TITLE IV-C MODEL PROJECTS
Enhancement of Services to Minorities

Continuations

Title	Recipient	FY 1981 Funds
Minority Service Enhancement Project	New York City Dept. for Aging New York, N.Y.	$ 80,000
Centro de Los Ancianos	Area Agency on Aging, Region I, Phoenix, AZ.	$ 80,000
Prototype for Area Agency on Aging to Enhance Services to Elderly	Area Agency County of San Diego, CA.	$117,000
Alternative Models for Operating Comprehensive, Coordinated Services to Elderly on Indian Reservations	Intertribal Council of Arizona	$ 54,617

LONG-TERM CARE
Channeling Demonstration Program

Research and Demonstration Projects

Title	Recipient	FY 1981 Funds
Channeling Demonstration Project	Florida Dept. of Health and Rehabilitative Services, Miami Jewish Home and Hospital for the Aged	$1,079,354
Channeling Demonstration Project	New York Office for the Aging, Rensselaer County Area Agency on Aging (AAA)	$ 991,246
Channeling Demonstration Project	Ohio Commission on Aging, Cuyahogo County AAA	$ 860,910
Channeling Demonstration Project	Pennsylvania Dept. of Public Welfare, Philadelphia Corporation for Aging (AAA)	$1,000,000
Channeling Demonstration Project	Texas Dept. of Human Resources, Texas Research Institute for Medical Sciences	$1,068,490

LONG-TERM CARE
AoA/HSA Demonstration Projects

Research and Demonstration Projects

Title	Recipient	FY 1981 Funds
System to Assure Elderly Services	Grace Hill Neighborhood Health Center, St. Louis, MO.	$ 10,000
Program of Health and Social Services for the Elderly Population of Rhode Island	Providence Ambulatory Health Care Foundation, Providence, R.I.	$ 25,000
Health Care Program for the Elderly	Centro de Salud de la Communidad de San Ysidro, San Ysidro, CA.	$ 24,954
Cherokee Nation Geriatric Health Program	Cherokee Nation Health Department, Tahlequah, OK.	$ 73,576
Geriatric Health Service	U.S. Public Health Hospital, Baltimore, MD.	$ 34,536
Use of Geriatric Nurse Specialists	Navajo Tribe, Fort Defiance, AZ.	$ 86,022
Seattle Comprehensive Health and Human Service Project	U.S. Public Health Hospital, Seattle, WA.	$ 32,775

LONG-TERM CARE
Long Term Care Model Projects

Research and Demonstration Projects

Title	Recipient	FY 1981 Funds
Long Term Care Planning Development	Pennsylvania Office for the Aging	$ 90,000
Wisconsin Regional Geriatric Center	Family Hospital, Milwaukee, WI.	$140,000
Deinstitutionalization Program	Senior Citizens Services, Inc., Memphis, TN.	$$132,802
Community Services Program	Pima County Board of Supervisors, Tuscon, AZ.	$185,561
Delivery of Medical/Social Services to the Homebound Elderly	New York City Dept. for the Aging, New York, N.Y.	$341,530
Extending ACCESS	Monroe County Long Term Care Program, Inc., Rochester, N.Y.	$132,300
Geriatric Assessment and Resource Center	Mental Health Program, Inc. Boston, Mass.	$123,750
Adult Restorative Services	Edgerton Medical Research Foundation, Wichita, KS.	$ 80,781

LONG-TERM CARE
Long Term Care Gerontology Centers

Research and Demonstration Projects

Title	Recipient	FY 1981 Funds
Long Term Care Gerontology Center	University of Arizona, Tucson, AZ.	$424,789
Long Term Care Gerontology Center	University of Kansas College of Health Sciences and Hospital, Kansas City, Kansas	$424,980
Milwaukee Long Term Care Gerontology Center	Medical College of Wisconsin, Milwaukee, Wisc.	$424,911
Long Term Care Gerontology Center	Temple University, Philadelphia, Pa.	$425,000

LONG-TERM CARE
Long Term Care Policy Analysis, Research, and Dissemination

Research and Demonstration Projects

Title	Recipient	FY 1981 Funds
Hispanic Support Systems and the Chronically Ill	Asociacion Nacional Pro Personas Mayores, Los Angeles, CA.	$ 74,875
A Youth Support System for the Frail Elderly	University of Southern California, Los Angeles, CA.	$ 88,549
Study of the Virginia Nursing Home Pre-Admission Screening Program	Virginia Commonwealth University, Richmond, VA.	$ 58,902
Demonstration of a Self-Help Approach to the Coordination of Human and Health Services	Dartmouth College, Hanover, N.H.	$120,938
Paths to Alternative Service Modalities and Differential Impact of Three Modalities on Similar Group of Vulnerable Elderly	Hebrew Rehabilitation Center, Boston, MA.	$174,446
The Effects on Families of Caring for Impaired Elderly in Residences	Benjamin Rose Institute, Cleveland, OH.	$131,086
On Lok Senior Services: A Community Care Organization for Dependent Adults	On Lok Senior Health Services, San Francisco, CA.	$191,074

LONG-TERM CARE
Long Term Care Policy Analysis, Research, and Dissemination

Research and Demonstration Projects

Title	Recipient	FY 1981 Funds
Continuum of Long Term Care: Health Care of the Elderly Research Fellowship Program	Gerontological Society, Washington, D.C.	$113,525
Options for a National Tax Credit Policy to Encourage Noninstitutional Long Term Care	National Opinion Research Center, Chicago, ILL.	$ 24,560
Commitment to Caregiving	Hunter College, New York, N.Y.	$ 69,467
Predictors of Successful Home Care Plans	University of Rochester, Rochester, N.Y.	$ 75,000

Title IV-E NATIONAL AGING POLICY STUDY CENTERS

Continuation Projects

Title	Recipient	FY 1981 Funds
National Aging Policy Study Center on Income Maintenance	Brandeis University, Waltham, Mass.	$218,241
National Aging Policy Study Center on Health	University of California, San Francisco, CA.	$218,142
National Aging Policy Study Center on Employment and Retirement	University of Southern California, Los Angeles, CA.	$273,203
National Aging Policy Study Center on Education, Leisure and Continuing Opportunities for Older Persons	National Council on Aging, Washington, D.C.	$154,215
National Aging Policy Study Center on Woman and Aging	University of Maryland, College Park, MD.	$187,521
National Aging Policy Study Center on Housing and Living Arrangements	University of Michigan, Ann Arbor, Mich.	$197,922

ADMINISTRATION FOR NATIVE AMERICANS

INDIAN ACCESS PROJECT

In fiscal year 1979, ANA entered into an agreement with the Administration on Aging to provide support to the National Indian Council on Aging (NICOA) to initiate a demonstration project on a number of Indian reservations for the purpose of increasing the number of elderly Indians receiving cash and other benefits from entitlement programs.

The Administration for Native Americans agreed to provide a sum not to exceed $85,000 per year for up to 3 years to support the demonstration project to increase the receipt of entitlements by elderly Indian people. In fiscal year 1979, ANA transferred $85,000 to the Administration on Aging to provide first year support for the project. In fiscal year 1980, funds in the amount of $85,000 were transferred via memorandum to OHDS budget from ANA to AOA to carry out the second year of the 3-year interagency agreement. Those fiscal year 1980 funds were awarded in September 1980 and funded fiscal year 1981 activities. In fiscal year 1981, the project was completed on four reservations.

TITLE XX

The Office of Human Development Services has responsibility for administering the social services programs authorized under titles I, IV–A, X, XIV, and XX of the Social Security Act, as amended. Except for Guam, Puerto Rico, and the Virgin Islands, title XX superseded all of the authorizing titles cited above as of October 1, 1975.

Under title XX, grants are made to States to deliver services under a comprehensive services program plan which is designed by each State to meet the needs of that State. At State option, services are delivered to individuals whose eligibility is based on income or income maintenance status. A person may be eligible for title XX services in four basic ways:

(1) By having an income which falls below 115 percent of the State's median family income for a family of four adjusted for family size.

(2) By being a recipient of aid to families with dependent children (AFDC) or supplemental security income (SSI).

(3) By being a member of a defined category of persons (e.g., persons living in a certain geographic area or members of a specified target group); or

(4) By being the recipient of a service provided by the State without regard to income. Three services may be provided by States without regard to income—information and referral, protective services, and family planning.

States may choose the services to be provided, as long as each service is directed to at least one of the five title XX goals, and at least three services are directed toward SSI recipients.

Various services directed to assisting the elderly to attain or maintain self-care and independence are provided through the social services program. Included are such services as adult day care, adult foster care, protective services, health-related services, homemaker, chore and transportation services, that assist elderly persons to remain or return to their own homes or to community living situations. Services are also offered which facilitate entry into institutions when appropriate.

It is not possible to determine a precise count of total recipients and expenditures related to services provided to the elderly since title XX data are collected by service and by category of eligibility of the recipients (e.g., AFDC and SSI). Data is available on the number of recipients and expenditures for services for those older persons eligible for SSI payments. The following are reported figures for fiscal years 1978 and 1979 for the number of primary recipients [1] and expenditures for the SSI-aged.

	SSI-aged primary recipients	Expenditures (Federal, State, local funds)
Fiscal year:		
1978	451,000	$262,000,000
1979	403,000	350,268,000

---

[1] Primary recipient: an individual with whom, or for whom, a specific goal is established and to whom services are provided for the purpose of achieving the goal. Services are considered to be provided to the primary recipient when they are provided to other members of the primary recipient's family to facilitate achievement of the primary recipient's goal.

These data understate the total number of elderly recipients and expenditures for services to the aged under title XX, since elderly persons other than SSI-aged qualify for, and receive, services from each of the services reported.

In fiscal year 1981, research and demonstration projects funded through the Office of Human Development Services tended to deal with areas in which elderly persons were among participants and may benefit from implementation of the research findings.

One research and demonstration project which deals specifically with the elderly, "Outcome of Social Services Provided to the Elderly in Milwaukee," was initiated in fiscal year 1981 and will continue through fiscal year 1983. Other projects in which the elderly may benefit significantly deal with topics such as adult protective services, unification of services, nonservice approaches to social welfare problems and transportation services.

The Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) was enacted into law on August 13, 1981. This act amends title XX of the Social Security Act to establish the Social Services Block Grant Act effective October 1, 1981. Under the Social Services Block Grant Act, each State will have complete flexibility in determining who is eligible to receive services, what services are to be provided, and how funds will be distributed among the various services offered in the State. In addition, States no longer will be required to develop detailed plans for implementing the title XX program, but instead will be able to develop briefer reports on the intended use of the funds they receive. This report must be submitted to the Secretary and made public within the State. Thus, each State can target its funds to meet its own local needs and, at the same time, it must answer to its citizens for spending decisions.

SOCIAL SECURITY ADMINISTRATION

Programs Administered by the Social Security Administration

The Social Security Administration (SSA) administers the Federal old-age, survivors and disability insurance (OASDI) program (title II of the Social Security Act). OASDI is the basic method in the United States of assuring income to individuals and families when workers retire, become disabled, or die. The basic idea of the cash benefits program is that, while they are working, employees and their employers pay earmarked social security contributions (FICA taxes); the self-employed also contribute a percentage of their net earnings. Then, when earnings stop or are reduced because of retirement in old-age, death, or disability, cash benefits are paid to partially replace the earnings that were lost. Current contributions are largely paid out in current benefits. However, at the same time, current workers build rights to future benefit protection.

SSA also administers the supplemental security income (SSI) program for aged, blind, and disabled people in financial need (title XVI of the Social Security Act). SSI provides a federally financed floor of income for eligible individuals with limited income and resources. In most cases, SSI supplements income from other sources including social security benefits.

The low-income home energy assistance program, which provides grants to States to help low-income household offset the rising costs of home energy, is also administered by the Social Security Administration.

SSA shares responsibility for the black lung program with the Department of Labor; SSA is responsible, under the Federal Coal Mine Health and Safety Act, for payment of black lung benefits to coal miners and their families who applied for those benefits prior to July 1973, and for payment of black lung benefits to certain survivors of miners.

Local Social Security offices process applications for entitlement to the medicare program and assist individuals in filing claims for medicare benefits. Overall, Federal administrative responsibility for the medicare program rests with the Health Care Financing Administration.

Following is a summary of beneficiary levels today, selected program activities, study groups, social security-related legislation enacted in 1981 and related activities.

I. OASDI BENEFITS AND BENEFICIARIES

At the beginning of 1981, about 94 percent of all Americans age 65 and over were drawing social security benefits or were eligible to draw benefits if they or their spouses retired; about 95 percent of the people who reached 65 in 1981 were eligible for benefits. It is expected that 96 to 98 percent of the aged will be eligible for social security benefits by the end of the century.

At the end of September 1981, 35.8 million people were receiving monthly social security cash benefits (an increase from 35.4 million in September 1980). Of these beneficiaries. 20 million were retired workers, 3.6 million were dependents of retired workers, 80,000 were uninsured individuals receiving "special age-72" (Prouty) benefits, 4.5 million were disabled workers and their dependents, and 7.6 million were survivors of deceased workers.

The monthly rate of benefits for September 1981 was $12.1 billion compared to $10.6 billion for September 1980. Of this amount, $8.4 billion was paid to retired workers and their dependents, $1.4 billion was paid to disabled workers and their dependents, $2.4 billion was paid to survivors, and $9 million was paid to special age-72 beneficiaries.

Retired workers received an average benefit for September 1981 of $384 (up from $340 in September 1980), while disabled workers received an average benefit of $414 (up from $370). Retired workers newly awarded social security benefits for September 1981 averaged $427, while disabled workers received an average initial benefit of $424. During fiscal year 1981 (October 1980 to September 1981), $136 billion in social security cash benefits were paid compared to $116 billion in fiscal year 1980. Of that total, retired workers and their dependents received $89.1 billion, disabled workers and their dependents received $16.9 billion, survivors received $29.9 billion, and special age-72 beneficiaries received $113 million. In addition, lump-sum death payments amounted to $370 million.

II. SUPPLEMENTAL SECURITY INCOME BENEFITS AND BENEFICIARIES

In 1981, SSI payment levels (like social security benefit amounts) were automatically adjusted to reflect a 11.2 percent increase in the CPI. Thus, beginning in July 1981, maximum monthly Federal SSI payment levels increased from $238 to $264.70 for an individual, and from $357 to $397 for a couple.

During fiscal year 1981, nearly $8.3 billion in benefits (consisting of $6.4 billion in Federal funds and $1.9 billion in federally administered State supplements) were paid. Of 4 million beneficiaries on the rolls during September 1981, 1.7 million were aged, and 2.3 million were receiving SSI based on blindness and disability, although 426,000 of them reached age 65 after they began to get payments. During September 1981, total payments of $736 million were made. The total payments in fiscal year 1981 represent an increase of about $0.8 billion over fiscal year 1980.

III. LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM

Beginning in October 1980, SSA was given Federal administrative responsibility for a program of low income energy assistance. The purpose of the program is to help low-income households avoid serious health and financial crisis by providing them assistance to meet the rapidly rising cost of home energy. Congress authorized in the Omnibus Budget Reconciliation Act of 1981, $1.8 billion for the Low Income Home Energy Assistance Act for fiscal years 19[illegible] through 1984. Block grants are made to States, territories, and eligible applicant Indian tribes. States, territories, and tribes may provide heating, cooling, and crisis intervention assistance and low-cost weatherization or energy-related home repair to income eligible households. Grantees can make payments to households with incomes within 150 percent of OMB poverty guidelines or within 60 percent of the State median income or to households which contain an individual who receives supplemental security income, food stamps, aid to families with dependent children, or needs-tested veterans' benefits.

IV. BLACK LUNG BENEFITS AND BENEFICIARIES

During September 1981, about 381,000 individuals received $88.4 million in black lung benefits which were administered by the Social Security Administration. These benefits are financed from general revenues. Of these individuals, 113,000 miners received $45.9 million, while 146,000 widows received $42.5 million. The miners and widows had 122,000 dependents. During fiscal year 1981, SSA administered black lung payments in the amount of $1.1 billion.

Black lung benefits increased by 4.8 percent in November 1981 due to an automatic general benefit increase adjustment under the law. The monthly payment to a coal miner disabled by black lung disease increased to $293 from $280. The monthly benefit for a miner or widow with one dependent is $440 and with two dependents is $513. The maximum monthly benefit payable when there are three or more dependents is $586.

V. SERVICE TO THE PUBLIC

The planning and managing of SSA's "service to the public" activities is one of the principal functions of the Office of Governmental Affairs. The goal is to increase SSA's responsiveness to public concern about all phases of the social security program—administration, policy determinations, and legislation—including benefit levels, entitlement to various benefit categories, and the financial status of the social security trust funds.

VI. INFORMATION AND REFERRAL ACTIVITIES

In 1979, SSA began an initiative to reassess the agency's role in information and referral for people in need of services beyond those provided through SSA administered programs. This reassessment, which was prompted by broadened program responsibilities, resulted in the issuance of updated and clarified instructions for regional and field office employees. These instructions stress the importance of providing needed information and referral services and provide detailed guidance to insure that SSA employees are familiar with and understand how to access services available in the community.

During 1981, surveys were conducted to measure the type and amount of information and referral activity, as well as the basic mechanism used by each office, the type of resource file most employed, and where outstationing is taking place. SSA will use this information to evaluate the new instructions and to ascertain whether further changes are needed.

VII. IMPROVED COMMUNICATION AND SERVICES

Improved Publications

Social Security's Office of Public Affairs completed its revisions of all major leaflets, simplifying the language and condensing the information on retirement, disability, and survivors benefits, as well as on the supplemental security income program, from 70 publications to 47. The leaflets were also redesigned to make them easier to use and more attractive.

Improved Notices To Beneficiaries

A continuing effort is being made to simplify manual and computer-generated notices so that beneficiaries can better understand them. Personalized notices are now being sent to people whose disability claims are denied. These notices include a brief summary of why the claim was turned down and a full explanation of the right to appeal the denial.

Notices to beneficiaries who have been overpaid are the next major category of notices that will be evaluated. Plans are being made now to present an explanation of the overpayment, Social Security Administration's repayment proposal and the right to appeal in simple, nontechnical language. Work on these simplified overpayment notices will continue as part of the Social Security Administration's debt collection project.

Amendment Information

A continuing effort has been made to publicize provisions of the 1980 disability amendments, particularly those designed to encourage beneficiaries who are still disabled to try to return to work. A wide variety of information materials also have been and will be produced in connection with changes under Public Law 97-35, the "Omnibus Budget Reconciliation Act of 1981," that included a number of social security and medicare program changes which affect older people.

Service To Hispanics

The Social Security Administration has increased the number of applications, forms, and notices available in Spanish for those who wish them. In addition, there are more public information materials available in Spanish. For example, the press office prepared several news releases and features aimed at Hispanics. And a pilot study is underway to determine the feasibility of disseminating a monthly newsletter (Information Items) for groups and organizations, now in English only, also in Spanish.

International Year of Disabled Persons (IYDP)

The United Nations designated 1981 as International Year of Disabled Persons (IYDP). During the year, the Social Security Administration was active in making its own employees and the public more aware of the potential and problems of people with disabilities. In addition, it took several actions to reduce physical barriers in its offices, to improve services for the blind and hearing-impaired people, and to enhance the career potential of its handicapped employees. Some of the agency's initiatives are of interest to older people, as 69 percent of disabled social security beneficiaries are 50 or older.

VIII. SSA ADMINISTRATIVE GOALS AND ACCOMPLISHMENTS

During fiscal year 1981, SSA placed major emphasis on maintaining acceptable speed and accuracy in initial claims decisions while implementing the disability amendments of 1980 and at the same time contending with major systems problems. In addition, emphasis was placed on reducing payment error rates in the various programs, and improving beneficiary services through the initiation of the upgrading of our nationwide telecommunications systems.

In fiscal year 1981, the accuracy of decisions in the claims processes was improved, and the time taken to process actions generally remained at satisfactory levels. The 1980 disability amendments have been implemented, although some final regulations remain to be published and certain changes to replace interim manual processes have not yet been completed. Actions have been and are being taken to increase the accuracy in measuring payment error rates and to reduce payment errors. The upgrading of the telecommunications system is proceeding.

For fiscal year 1982, emphasis will continue to be placed on providing prompt and accurate beneficiary services. Other major thrusts in fiscal year 1982 will be to: Improve the administration of the disability program; improve debt management; and develop and begin implementing a plan to modernize SSA's computer operations.

IX. NATIONAL COMMISSION ON SOCIAL SECURITY

The National Commission on Social Security, established by the 1977 Social Security Amendments, released its final report on March 12, 1981. The report, which included 88 recommendations covering all aspects of the social security system, was the culmination of a broad-scale, comprehensive study of social security, including medicare. The Commission had issued interim reports on May 11, 1979, and January 11, 1980.

To meet short-range financing problems, the Commission unanimously called for borrowing on a permanent basis when needed between the trust funds to meet cash-flow problems in the system and for emergency borrowing from general revenues until 1985 to assure timely payment of benefits if revenues prove inadequate. The Commission stated that these financing changes would make clear to the public that Congress will not permit any interruption of benefit payments.

To meet long-term financing needs, a majority of the members recommended financing one-half of the cost of the hospital insurance program through Federal general revenues and shifting to the retirement, survivors, and disability programs any reduction in the hospital insurance payroll tax rates that could be accommodated without hospital insurance trust fund reserves falling below the following year's outgo at any time over the next 75 years. A majority also urged that the minimum retirement age for unreduced benefits be gradually raised from 65 to 68, over the period 2001 to 2012.

The Commission also recommended that the automatic adjustment of benefits based on the Consumer Price Index (CPI) be modified if over a 2-year period, the average increase in the CPI exceeds the average increase in wages, and if the increase in the CPI applicable to the current year is at least 5 percent. During this period, the increase should be limited to the increase in the CPI for the past year, reduced by the excess of the 2-year average annual rise in CPI over that in wages. There would be a retroactive "catch up" in future years, if wages rise more rapidly than the CPI.

In addition, the Commission recommended that social security coverage should be extended in 1982 to all State and local employees not under a retirement system and to employees of nonprofit organizations. Social security coverage should be extended to all government employees—including Federal employees, and State and local employees under a retirement system—hired after 1984.

X. PRESIDENT'S COMMISSION ON PENSION POLICY

The President's Commission on Pension Policy, established by Executive Order in July 1978, to examine pension systems around the country in an effort to develop national policies for retirement, survivor, and disability programs that could serve as a guide for public and private programs, submitted its final report to the President on February 26, 1981. The Commission had issued interim reports in May 1980 and November 1980.

The Commission recommended providing for retirement years through a balanced program of employee pensions, social security and individual effort with the social security system providing a minimum floor of protection for the aged. The major recommendations of the Commission are to:

—Establish a minimum universal pension system covering all workers.

—Raise the minimum eligibility age for unreduced social security benefits by 3 years, phased in beginning in 1990.

—Mandate universal social security coverage.

—Tax social security benefits, coupled with tax deductions/credits for payroll contributions and phasing out the earnings test.

—Allow refundable tax credits for retirement savings.

—Provide a separate cost-of-living index for the retired.

—Change to once-a-year cost-of-living adjustments for Federal retirees.

—Raise SSI benefits to the poverty line.

XI. PRECEDENT-SETTING COURT DECISIONS THAT AFFECT THE ELDERLY MADE DURING FISCAL YEAR 1981 OR STILL PENDING

Yamasaki—Title II—Personal Conferences

In June 1979, the U.S. Supreme Court ruled in *Yamasaki* that SSA must provide a title II beneficiary with an opportunity for a prerecoupment personal conference before a request for waiver of an outstanding overpayment can be denied. SSA and plaintiffs' attorneys differ in the interpretation of the Supreme Court's decision. SSA has interpreted the court decision as requiring SSA to provide an individual an opportunity for a personal conference. The plaintiffs' attorneys view *Yamasaki* as requiring SSA to automatically schedule a personal conference in every case. Recently, two district courts have ruled in favor of the plaintiffs' interpretation of *Yamasaki*. At the direction of the court, procedures implementing automatic scheduling of conference have been ordered in the State of Hawaii. It is expected that the other district court that controls the nationwide class on this issue will order implementation of automatic scheduling shortly. It has been estimated that implementation of the plaintiffs' interpretation of *Yamasaki* will cost approximately $10 million. SSA has recommended that these adverse decisions be appealed to the circuit court.

Government Pension Offset

There has been considerable litigation this past year involving the operation of the Government pension offset. Basically the pension offset provides that an individual's social security spouse's benefits (including surviving spouse's benefits) are reduced by the amount of any pension the spouse may receive based on his or her own work in governmental employment not covered by social security. Congress, in enacting the Government pension offset in 1977, provided a 5-year exemption from the offset for those individuals who could meet the requirements for entitlement to spouse's benefits under the provisions of the Social Security Act as of January 1977. The dependency requirement for husband's and widower's benefits was held unconstitutional by the Supreme Court in March 1977. Since the statute required a dependency test before benefits could be awarded in January 1977, the effect of the pension offset is that men who are entitled to husband's and widower's benefits are generally excluded from the 5-year pension offset exception.

The challenges to the Government pension offset have been basically twofold: (1) The plaintiffs allege the offset deprives them of due process and equal protection, and (2) the offset perpetuates the same gender-based classification struck down by the Supreme Court when it ruled the dependency requirement unconstitutional.

The courts have generally upheld the pension offset provision in the past. However, in *Webb* v. *Harris* the U.S. District Court for the Northern District of California held that husbands and widowers do not have to meet the one-half support test in order to avoid the offset; the Government has appealed.

Dockstader—Electronic Funds Transfer

In *Dockstader* on July 22, 1981, the district court entered a judgment in favor of the Government and held that payments made after a beneficiary's death by direct deposit via electronic funds transfer (EFT) are not overpayments which are subject to normal SSA overpayment recovery procedures. In accordance with SSA policy and Treasury regulations payments made after an individual's death and converted for the use of a joint bank account holder (e.g., the spouse of the deceased beneficiary) are subject to reclamation by Treasury. That is, the Treasury immediately requests the bank to debit the incorrect moneys paid from an individual's bank account and a refund, if a balance is still outstanding, is requested from the account holder. There are currently pending several other cases in various jurisdictions in the country involving this issue.

Kimmes—SSI In-Kind Income—Private Rental Subsidy

On October 13, 1981, the U.S. Supreme Court denied the plaintiff's petition for a writ of certiorari. Plaintiff had sought Supreme Court review of the Tenth Circuit's April 22, 1981, decision upholding the Secretary's interpretation of the meaning of unearned income found in section 1612(a)(2)(A) of the act. The circuit court affirmed the Secretary's determination that the difference between the expenses incurred by the plaintiff in connection with her rent-free use of a trailer and the market rental value of the trailer constituted in-kind income. The Sixth Circuit ruled that the economic benefit of rent-free housing constitutes actually available in-kind unearned income and that it is "of no moment" that the economic benefit is not a cash benefit.

XII. SUMMARY OF LEGISLATION ENACTED IN FISCAL YEAR 1981 THAT SIGNIFICANTLY AFFECTS SSA

Public Law 96–403 (H.R. 7670), Reallocation of OASI and DI taxes—Signed on October 9, 1980

Reallocates OASDI taxes to shift income from the DI trust fund to the OASI trust fund for calendar year 1980 and calendar year 1981.

Public Law 96–422 (H.R. 7859), Refugee Education Assistance Act—Signed on October 10, 1980

Title V of this law:

Mandates Federal reimbursement of expenses (including, by interpretation, State supplementary payments under the SSI program and the State share of AFDC payments) to State and local governments for services provided in resettlement of Cuban/Haitian entrants. It is the intent that Cuban/Haitian refugees be treated as other refugees are under the Refugee Act of 1980. Moneys authorized under the supplemental appropriations act for fiscal year 1980 will be made available for carrying out this intent.

Gives the President discretionary authority to provide to Cuban/Haitian entrants any other benefits which are granted to refugees under existing law.

Permits Federal reimbursement for services provided by State and local governments any time after the arrival of the Cuban/Haitian entrants in the United States, including periods prior to October 10, 1980.

Defines a Cuban/Haitian entrant for purposes of the foregoing provisions to include, in addition to those granted the special parole status, any other Cuban or Haitian national whose immigration status as a permanent resident is unsettled.

Public Law 96–473 (H.R. 5295), Social Security Earnings Test, Separate Entitlement to Medicare, and Suspension of Disability Benefits to Prisoners—Signed on October 19, 1980

This law restores the use of the monthly earnings test for certain beneficiaries; provides for separate entitlement to cash benefits and medicare; excludes from the earnings test self-employment income which was earned prior to, but received after, entitlement; and restricts the payment of social security disability benefits to certain convicted felons.

Public Law 96–481 (H.R. 5612), Amendments to Small Business Act—Signed on October 21, 1980

Title II of this law provides that the prevailing parties in proceedings for or against the United States may be awarded attorneys' fees and other costs related to the proceedings, unless the Government can show its position was substantially justified or that special circumstances make an award unjust. The provision applies to social security cases at the court level.

Public Law 96–499 (H.R. 7765) Omnibus Reconciliation Act of 1980—Signed on December 5, 1980

This law contains social security-related provisions to limit benefit retroactivity to 6 months, except for disability claims (which could still have 12-month retroactivity); include in wages the employee social security taxes paid by an employer (except for domestic and agricultural employees), but the provision would not apply, until 1984, for State and local employers who were paying a substantial portion of the employee's taxes as of October 1, 1980; delay implementation of Federal child day care regulations to July 1, 1981; and provide for demonstration projects in up to 12 States to train and employ AFDC recipients as home health sides.

Public Law 96–533 (H.R. 6942), International Security and Development Cooperation Act of 1980—Signed on December 16, 1980

Includes provisions for granting fiscal relief for States and local subdivisions which bear a disproportionate share of the costs of absorbing and resettling the recent Cuban and Haitian emigrees.

Public Law 96–541 (H.R. 6975), Hardwood Veneer Tariffs—Signed on December 17, 1980

Includes a provision that extends (for January 1, 1981 through June 30, 1982) the period of interim relief from certain employment tax liability (provided by the Congress in Public Law 96–167) to businesses that have been treating workers as independent contractors rather than as employees. To be eligible for relief, a business must have a reasonable basis for treating a worker as an independent contractor and must not have treated such a worker as an employee for tax purposes during specified periods.

Public Law 96–598 (H.R. 3317), An Act for the Refund of Excise Taxes on Certain Uses of Tread Rubber—Signed on December 24, 1980

Contains a private relief provision deeming the Bonners Ferry (Idaho) Community Restorium not to meet the definition of "public institution" in the SSI law. The effect of the provision is to make eligible for SSI benefits residents of the Restorium who now meet all requirements for SSI except for their residence in a "public institution." (SSA had been paying SSI benefits to 11 residents of the Restorium under court order.)

Public Law 96–605 (H.R. 7956), Miscellaneous Revenue Act of 1980—Signed on December 28, 1980

Includes a provision introduced on behalf of the Manhattan Bowery Corp. to excuse nonprofit corporations which meet certain requirements from liability for social security employee taxes due on wages of certain employees for the period January 1, 1973 through June 30, 1977, and from paying interest and penalties on the taxes due. The wages in question would be credited to the employees for purposes of determining their entitlement to social security benefits and the amount of those benefits.

Public Law 96–611 (H.R. 8406), Pneumococcal Vaccine Act of 1980—Signed on December 28, 1980

Among other provisions, limits SSI and medicaid eligibility in cases where applicants dispose of assets for less than fair market value.

Public Law 97–35 (H.R. 39–82), Omnibus Budget Reconciliation Act of 1981—Signed on August 13, 1981

Makes the following changes in old age, survivors, and disability insurance (OASDI) and supplemental security income (SSI), and establishes a block grant for low-income and home energy assistance (LIHEAP):

OASDI provisions

Minimum benefit.—Eliminates the regular minimum benefit for months after October 1981 for all beneficiaries who initially become eligible for benefits after that date. The minimum benefit is eliminated for benefits payable for months after February 1982 for all other beneficiaries. Provides that recipients age 60 through 64 who get their minimum benefits reduced under this provision, and who would be eligible for SSI benefits under present law if they were age 65, can receive an SSI payment in an amount not to exceed the difference between their newly reduced social security benefit and the amount which they had been receiving under prior law. This special-SSI payment will not be adjusted for changes in the cost of living, nor will the recipient be entitled to State supplementary payments or to other benefits such as food stamps or medicaid as a result of receiving the special SSI payment.[1]

Student's benefits.—Eliminates benefits to new postsecondary students age 18 to 21 who are full-time students at institutions of higher education or other postsecondary schools and allows benefits to elementary or secondary students only up to age 19, effective with benefits payable for August 1982. Certain students who begin postsecondary school before May 1982 may continue to receive benefits up until age 22; however, these benefits will be reduced 25 percent each year, and no cost-of-living adjustments or summer-month benefits will be paid.

Disability offset.—Extends the workers compensation (WC) offset concept by providing for a disability offset (the so-called meagcap) under which a worker's social security disability benefits are reduced (if necessary) so that the sum of disability benefits payable under Federal, State, and local public programs (with certain exceptions such as Veterans Administration benefits) will not exceed the higher of 80 percent of the worker's "average current earnings" or the disabled-worker family's total social security benefits.

Also modifies the prior WC offset by extending the disability offset to disabled workers age 62 to 64, and by making the offset effective with the month of the individual's first concurrent entitlement to social security disability benefits and other disability benefits, instead of the month of application for social security disability benefits or, if later, the month in which the Secretary is notified of such other entitlement. In addition, the prior restriction against the offset when a State plan calls for reducing State WC benefits because of receipt of social security disability benefits, is limited to those States having such a plan in effect on February 18, 1981.

Terminates mother's and father's benefits when child attains age 16.—Ends entitlement for the mother or father caring for a child who receives child's benefits when the child reaches age 16 (rather than age 18, as under prior law).

Payment of benefits in month of entitlement.—Provides that workers and their spouses (including divorced spouses) may not receive old-age benefits for a month unless they meet the requirements for entitlements throughout that month. The major effect, in the vast majority of cases, is to postpone entitlement to old-age benefits for persons who claim benefits in the month in which they reach age 62 to the next month.

Lump-sum death payment.—Provides that effective for insured workers who die after August 1981, the $255 lump-sum death payment may be paid only to the spouse living with the worker at the time of death or to a spouse (excluding a divorced spouse) who is eligible for widow's or widower's benefits for the month in which the worker died. If there is no spouse eligible for the payment, it will be made to children who are eligible for monthly benefits in the month of death.

Rounding benefits.—Provides that ASDI benefit amounts will be rounded to the next lower 10 cents at every step of the benefit calculation and then to the next lower dollar (after deducting any SMI premium) at the final step.

Retain social security earnings test exempt age at 72 through 1982.—Retains, through 1982, age 72 as the upper age limit at which the earnings test no longer applies; beginning in 1983, the limit will be age 70. (Under prior law, the upper age limit at which the earnings test no longer applies would have been lowered from 72 to 70 beginning in 1982.)

---

[1] H.R. 4331, which was passed by the Senate on December 15, 1981, and the House on December 16, 1981, would restore the minimum benefit for all people who are eligible for benefits before January 1982, or whose benefits are based on a worker's eligibility or death before January 1982. For members of religious orders who have taken a vow of poverty and who were first covered under social security prior to enactment of H.R. 4331, the minimum benefit would be eliminated for those who become eligible for benefits after December 1991. The special-SSI payment included in Public Law 97–35 would be repealed by H.R. 4331.

Reimbursement of States for successful rehabilitation services.—Provides that the cost of vocational rehabilitation (VR) services provided by the States to social security disability beneficiaries will be reimbursed from the trust funds only if the disabled beneficiaries successfully engage in substantial gainful activity (SGA) for 9 continuous months and if the VR services contributed to the successful return to SGA.

Pension information reimbursement.—Authorizes the Secretary to charge requestors the full cost of furnishing detailed earnings information to enable an employee benefit plan to comply with the Employee Retirement Income Security Act or for any other purpose not directly related to the administration of the programs under the Social Security Act.

SSI provisions

Special SSI benefits for people 60 through 64 years old.—See earlier summary of social security minimum benefit provision.

Uncashed SSI checks.—Establishes a process for crediting a State for which SSA is making State supplementary payments with its share of SSI checks that remain unnegotiated for 180 days after the date of issue. An SSI check that is presented for payment after the State has been credited with its share of the payment will be honored. In these cases, the State will be recharged for its share of the amount of the paid check.

The Treasury Department is required to notify SSA monthly of outstanding uncashed checks and SSA will credit States for their shares of that amount. SSA is required to investigate the reason the checks have not been cashed.

Food stamp cash-out.—Changes the criteria for determining whether a State is providing cash in lieu of food stamps to its SSI recipients and, therefore, whether SSI recipients in that State may receive food stamps. Effective July 1, 1981, at the State's request the Secretary will find that the State is cashing out food stamps for SSI recipients by including the value of food stamps in its State supplementary payment levels if the State had cash-out status in December 1980 and continues without interruption to pass though cost-of-living increases in Federal SSI benefits to persons receiving State supplementary payments. Thus, the law permits California, Massachusetts, and Wisconsin, the only States that had cash-out status in December 1980, to continue to provide cash in place of food stamps for their SSI recipients, so long as they meet the passthrough requirements.

Funding of rehabilitation services for SSI recipients.—Similar in effect to the reimbursement conditions provided for VR to social security disability beneficiaries except that the cost of VR services provided by the States to blind or disabled SSI recipients will be reimbursed from general revenues. SSA is still required to refer blind or disabled SSI recipients age 16 or older for VR services, and blind and disabled SSI recipients will continue to be required to accept VR services as a condition of SSI eligibility.

Health services for SSI children.—Retains the mandatory referral of disabled or blind children under the age of 16 for medical, educational, and social services but deletes the funding authority to provide reimbursement to States that provide such services to SSI recipients who are under age 16.

Monthly retrospective accounting.—Changes the method of computing the SSI benefit to one under which the benefit amount is computed on a monthly basis and is based on income, living arrangements and other conditions in the previous (or second previous) month. Eligibility, however, will be determined based on the current month's circumstances, and both eligibility and the amount of the benefit will be determined based on the current month's circumstances for those applying for the first time and for those for whom benefits are being reinstated following a period of ineligibility.

The provision also gives the Secretary authority to waive the restrictions on eligibility for people in certain public institutions or the $25 limit on the payment amount applicable for people in medicaid certified facilities if waiving such restrictions will facilitate the individual's release from the institution. This will permit the Secretary to pay benefits, in the month an individual leaves an institution, in an amount appropriate to his or her new living arrangement.

LIHEAP provisions

Appropriations and allocation of funds.—Repeals the "Home Energy Assistance Act of 1980" effective October 1, 1981, and replaces it with the "Low-Income Home Energy Assistance Act of 1981." Authorizes $1.875 billion for each of the next 3 fiscal years (fiscal years 1982, 1983, and 1984). Between 0.1 percent and 0.5 percent of these funds must be used for energy assistance in the territories and the remainder is to be allocated to States and the District of Columbia. Each State receives the same proportion of Federal funds appropriated under this act as it received during fiscal year 1981 in connection with the repealed act. No State match is required. Indian tribal organizations may receive a pro rata share of a State's allocation by submitting an appropriate plan directly to the Secretary.

State requirements.—Although LIHEAP is authorized as a block grant, States must submit an annual application for funds under this program, and that application must contain assurances that all requirements in the act will be met. Specifically, States may serve only beneficiaries of certain Government programs and other low-income households. They must initiate an outreach program and, by the second year, conduct public hearings. They must also maintain adequate controls and undertake periodic audits, provide fair hearings and not discriminate.

Use of funds.—States are permitted to use up to 10 percent of their allocations for administrative costs with any additional administrative costs being met by States. They may use no more than 15 percent of these funds for weatherization and they must reserve a reasonable amount for weather-related and/or supply-shortage emergencies.

States may direct up to 10 percent of their allocations to certain other federally assisted programs (i.e., community or social services) and carry over into the following fiscal year up to 25 percent of these funds. Benefits under this program may be paid to eligible households or to energy suppliers.

HEALTH CARE FINANCING ADMINISTRATION

Long-Term Care Research and Demonstrations

INTRODUCTION

Because the Health Care Financing Administration (HCFA) is the primary source of funding for long-term care services in the United States, it has an inherent interest in seeking alternative approaches to the delivery and financing of this care. The medicaid program is the principal payor of long-term care services, with Federal and State payments in fiscal year 1979 of approximately $7.1 billion for skilled nursing and intermediate care facility services and an estimated $263.5 million for home health services. That same year, the medicare program spent approximately $358 million for skilled nursing facility services and $624 million for home health services.[1]

The population at risk of long-term care services is small but growing. In 1980, about one out of nine persons was 65 and over. However, in the next 50 years, nearly one in five persons will be elderly. Expressed in absolute terms, the 25.5 million elderly in 1980 will become 55 million in 2030.[2] Data also indicate that currently three-fourths of all nursing home residents are 75 and over, and more than one-third are 85 years and older.[3] However, the aged are only one segment of the long-term care population.

The adult disabled constitute a substantial element of the population with long-term care needs. Approximately 23 percent of the population over the age of 18 have at least some limitation in their physical functioning.[4]

Data have also been reported which indicate that the number of adult disabled under age 65 who have severe impairments is equal to the number of impaired persons over 65 years of age.[5]

Still another segment of the long-term care population are the mentally retarded and developmentally disabled. Developmental disabilities are defined as

---

[1] Budget of the U.S. Government, fiscal year 1981: Appendix, U.S. Government Printing Office, Washington, D.C., 1980. Health Care Financing Administration, "National Annual State Medicaid Statistical Report," U.S. Government Printing Office, Washington, D.C. 1981.

[2] U.S. Bureau of the Census, Current Population Reports, Series P–20, No. 363, "Population Profile of the United States: 1980," U.S. Government Printing Office, Washington, D.C., 1981. U.S. Bureau of the Census, Current Population Reports, Series P–25, No. 704, "Projections of the Population of the United States: 1977 to 2050," U.S. Government Printing Office, Washington, D.C., 1977.

[3] Statistical Reports on Older Americans, "Some Prospects for the Future Elderly Population," Administration on Aging, January 1978.

[4] National Long-Term Care Project: Final Report, University of Chicago Center for the Study of Welfare Policy, August 1980.

[5] Budget Issue Paper, "Long-Term Care for the Elderly and Disabled," Congressional Budget Office, February 1977.

those conditions attributable to mental retardation, cerebral palsy, epilepsy, or other related conditions. Mental retardation is defined on the basis of IQ as well as adaptive behavior. Recent estimates set the number of mentally retarded persons of all ages in the United States at 6 million, of whom 670,000 are diagnosed as severely handicapped. Of the remaining developmentally disabled population, 580,000 are estimated to have cerebral palsy, 206,000 are epileptics, and 600,000 have other neurological disorders including muscular dystrophy and speech and hearing disorders.[6] Within this segment of the long-term care population alone, there are several levels of impairment, from the profoundly retarded who require total and constant care, to the moderately retarded who might be able to manage some personal tasks with supervision, to the mildly retarded, who are often able to care for themselves and hold jobs. This latter subgroup are often able to live in a sheltered environment or alone.[7]

The adult chronically mentally ill make up another growing portion of the long-term care population. Mental disorders affect up to 15 percent of the population in the United States during any given year.[8] The President's Commission on Mental Health reports that the direct cost of mental health services in the midseventies exceeded $17 billion per year representing 12 percent of total national health care expenditures. In addition, the mentally ill have higher than average rates of physical illness, using medical services at almost twice the rate of the nonmentally ill population.[9] Primary diagnosis data from 1976 and 1977 reveal that 800,000 mentally ill people were residents in nursing homes during that time. This accounts for upwards of two-thirds of the total nursing home population.[10]

The terminally ill who require care for an extended period of time, such as persons suffering from certain terminal forms of cancer, also fall within the long-term care population.

It is generally agreed that there is some overlap between these groups in terms of their long-term care needs but little is known about their characteristics and how their needs intersect or how they might be unique. This raises the issue that is at the core of the policymaking dilemma in long-term care: the lack of a precise definition of long-term care in terms of the nature of what constitutes such care and who should receive it.

The distinguishing feature of the long-term care population has been described as their inability to carry out certain routine daily tasks. Under the current service delivery system, the severity of the condition, combined with personal characteristics such as age, income, living arrangements, and availability of an informal support system, are the factors which often arbitrarily provide answers to questions about the type of care received and who should receive it. However, it has become increasingly evident to all levels of government and to consumers, that these factors are interrelated. No single aspect—diagnoses, age, income, etc.—can easily be used to determine the need for one type of care or treatment over another.

A good deal of interest has recently been directed at the financial and human implications of an inadequate service delivery system and the resulting placement of patients in inappropriate levels of care, especially those who have been inappropriately placed in institutional settings. Various studies have indicated that anywhere from 15 to 50 percent of institutional residents could be better served at a lower level of care. [11] However, because of the multifaceted nature of the long-term care populations, as noted earlier, levels of care cannot be easily quantified or determined, regardless of whether the care is provided in an institutional setting or in the patient's home. The challenge has been to develop a delivery system that has the capacity to strike a balance between meeting dependency needs of the long-term care patient, while simultaneously avoiding cutting off opportunities for rehabilitation and independent living.[12]

During the past several years, public opinion and professional concern has been focused on the availability and appropriateness of community-based long-term care. Specific efforts have been directed at the organization and delivery of community-based long-term care services, their financing and reimbursement, control of quality and abuse, the definition of eligibility, and coordination of services.

---

[6] LaVor, Judith, "Long-Term Care: A Challenge to Service Systems," Long-Term Care, Praeger, 1979.

[7] LaPorte and Rubin, "Long-Term Care," Praeger, 1979.

[8] Archives of General Psychiatry, Volume 35, June 1978.

[9] Analytical Review of the Literature, Mental Disorder and Primary Medical Care, Services D. No. 5. National Institutes of Mental Health, 1974.

[10] Wallack, Stanley, "Services for the Chronically Mentally Ill: The Implications of Financing," Frandeis University Health Policy Consortium, 1979.

[11] For a discussion of these studies, see General Accounting Office, "Entering a Nursing Home: Costly Implications for Medicaid and the Elderly," report to the Congress of the United States, 1979.

[12] University of Chicago Center for the Study of Welfare Policy, 1980.

A major generating force behind the increasing governmental interest in community-based care is the desire for a means of controlling escalating long-term care costs. Community-based care has been advanced as an economy measure; however, the cost effectiveness of community "alternatives to institutionalization" have not yet been proven in the aggregate. True costs of delivering long-term care in the community have been difficult to measure or predict.[13] The costs per unit of service are only now becoming available, but from a public policy perspective, it may be equally important to learn the total (system) cost of caring for a given individual with certain characteristics over a period of time.

In determining the appropriate type and level of care for an individual, various value considerations come into play, not all of which are mutually compatible. For example, independence, self-determination, individualization and normalization may clash with the goals of equity, economy, right to treatment, protection from harm and the protection of society.[14] None of these factors are easily measured but from the consumer's and the general public's perception, they are the key determinants of whether or not long-term care is effective or responsive to their needs. In the final analysis, these factors may be as important as cost in developing a comprehensive long-term care strategy.

In summary, the major debates in the field of long-term care resolve around the following three policy and analytical issues: (1) The long-term care population especially the group at risk of institutionalization, will continue to grow; (2) publicly supported costs of long-term care are growing rapidly and currently represent a response only to institutional long-term care needs; and, (3) the current mix of long-term care services and financing is either the most efficient nor the most responsive to the needs of the groups that comprise the long-term care population.

Many groups both in the private and public sector are investigating the implications of these issues for society and the health care system. HCFA's research and demonstration activities in long-term care examine several aspects of these issues as they relate to the medicare and medicaid programs.

HCFA Research and Demonstration Efforts

HCFA's Office of Research, Demonstrations, and Statistics (ORDS) conducts a program of research, demonstrations, and evaluations in long-term care, particularly as long-term care relates to the populations and services covered by medicare and medicaid. Within ORDS, both the Office of Research and the Office of Demonstrations and Evaluations are involved in the area of long-term care. In general, long-term care *research* activities involve the use and analysis of existing data, either collected by survey or abstracted from other data sources. Long-term care research has focused primarily on describing and explaining the demand for long-term care and the basic economic underpinnings of the long-term care industry. In addition, considerabe effort has been given to the development of a methodology to measure the quality of long-term care provided in different settings. The purpose of this research is to develop an understanding of long-term health care delivery, reimbursement and financing systems in order to provide some direction for private and public policymaking and to identify promising areas for demonstration activities.

ORDS' long-term care *demonstration* (experiments) require the development of a rigorous research design and, within the design, a specific intervention is introduced into a live situation with subsequent observation of the outcomes. Evaluation findings form the basis for future policy recommendations regarding the medicare and medicaid programs.

LONG-TERM CARE RESEARCH—OVERVIEW

The role of the ORDS long-term care research program is to povide vital information relating to current and anticipated policy issues related to the goals of the Department of Health and Human Services. Most critical are those areas which will provide information about how to contain costs while increasing the efficiency and rationality of the long-term care system. The research program includes congressionally mandated studies and research on fundamental issues which underlie a multiplicity of current and prospective policy questions.

---

[13] Ibid.
[14] Ibid.

The long-term care research program consists of both intramural and extramural dimensions, which are intended to be complementary. On the intramural research side, for example, we have recently reviewed several major issues of direct and basic importance to the long-term care system in the United States. The results of this study have recently been compiled and produced in a book entitled "Long Term Care: Some Perspectives from Research and Demonstrations." This report is in the process of being printed.

Our extramural research program is similarly oriented to provide policymakers the necessary data for enhancing policy formulation and program development. Four project areas are discussed below:

I. Determinants of demand for long-term care.
II. Policy effects on long -term care utilization and costs.
III. Nursing home costs, quality, and reimbursements.
IV. Mental retardation/developmentally disabled.

I. Determinants of Demand for Long-Term Care

Research activities are being supported to explore determinants of the demand for long-term care services. The seven studies in this group include research on: (1) The demographic and epidemiological factors affecting long-term care, (2) interrelationships among the elderly, their families, and other informal supports and demand for long-term care services, and (3) interactions between noninstitutional and institutional long-term care services.

In the first area, Duke University is studying the health status of the U.S. population using a model of the natural history of important chronic diseases. This model, which integrates evidence from several sources (vital statistics, epidemiological studies, clinical fundings, and physiological models) will be used to produce distributions of chronic diseases. With more accurate estimates of the prevalence and incidence of chronic diseases, better estimates of health care costs, particularly those for long-term care services, can be derived. Results of this project are available on a continuing basis as projections of different chronic diseases are developed.

In the second area, there are five projects which are investigating the interrelationships among the elderly, their families, and demand for long-term care services. A study conducted by the University of Michigan identified relationships between certain characteristics known at the time clients enter home health care and their utilization patterns and status of discharge. One finding was that characteristics of a personal and familial nature had a weaker relationship to intensity of service than payment characteristics. The study was completed in early 1981 and the final report is available.

A study by Hunter College is examining the family care-giving systems of the frail elderly. It will document the types of services they provide and the social and economic impacts they experience in doing so. It will identify factors that strengthen or weaken the family system in providing care to the elderly and recommend methods of enhancing the family care-giving system which would sustain the elderly in the community and avoid more costly alternatives. Results of the study will be available in mid-1982.

A study being conducted by the Community Service Society is examining the effects of providinng substantial ongoinng home service programs to functionally disabled low-income adults. Issues being explored include:

(1) Whether those using home services will experience better solutions to problems of daily living.

(2) Whether availability of home services will diminish use of in-patient hospital services and long-term care institutions; and

(3) Whether home services will reduce but not eliminate family participation in care.

This study will be completed by mid-1983.

Virginia Commonwealth University is conducting a study to followup individuals admitted to nursing homes in Virginia who had been assessed by the preadmission screening program. This group will be compared with: (1) Those who were screened but not admitted to nursing homes, (2) those in nursing homes who were not screened, and (3) individuals in the community who are at a high risk of institutionalization. This project will provide information about what services and supports the elderly need to remain in the community, including services provided by families and other informal supports. In addition, costs will be compared of alternative health and social services for community and institutional and rural and urban settings. The study will be completed in late 1982.

A study by Community Research Applications examined black, white, Puerto Rican, and Mexican American consumers' information about and attitudes toward various types of long-term care services including community alternatives and institutional care. This study was completed in early 1981.

The third area consists of a study conducted by the American Association of Homes for the Aged. This grant is examining what factors influence the provision of noninstitutional care by home for the aging. Data are being gathered on: (1) Community characteristics of the homes, (2) recipient characteristics, (3) outreach program description, and (4) funding characteristics. The project will address the issue of how to provide support for noninstitutional long-term care without large increases in medicare and medicaid program outlays.

The results of the study will be available in December 1981.

II. Policy Effects on Long-Term Care Utilization and Costs

Research activities are being supported to clarify the relationships between policies and the utilization and costs of long-term care. The broad focus of 4 of the 10 studies in this group is on the effects of existing policies on the distribution and composition of long-term care patients and providers. In addition, some of these also assess the impact of policies on costs of care. The remaining six studies in this group are directed toward developing a better understanding of the components of costs for long-term care for the purpose of enhancing future policy deliberations.

In the first group of studies, three projects are investigating the impact of State and Federal policies on long-term care utilization. The University of California, San Francisco is examining the impact of State discretionary policies on the availability and utilization of long-term care, as well as the policy effects on the total cost and distribution of Federal, State, and local expenditures. This project will be completed in late 1983. A second study by the University of Texas, Dallas, investigated, on a statewide basis, the impact of public expenditures for a variety of noninstitutional long-term care alternatives on the pattern of nursing home utilization. The third study is examining the impact of a statewide patient review system on utilization. This study by Rhode Island Health Services Research will study the effectiveness of an ongoing utilization review in nursing homes on patient placement, eligibility, and quality of care. Results from this 1-year study will be available in mid-1982.

The last study in this group is the examination of the behavior of physicians in long-term care. The Center for Health Economics Research will analyze the factors that influence physician willingness to make nursing home visits. In particular, the study will examine the respective roles of medicare reimbursement rates and medicare disallowaces on physician long-term care practices. This project was recently funded. Results will be available in mid-1983.

In the second group of studies, two grantees, the University of Colorado and Yale University, are examining the relationship of case mix, quality, and costs of nursing home care. The Colorado study is in the final year of 3 years and findings will be available by mid-1982. Preliminary findings from this study indicate that groups of diagnoses and long-term care problems cluster together by facility, suggesting that there are very likely specific facility groupings which emphasize care for similar types of patients. In addition, this study has found that certain case mix measures appear to vary in accord with specific facility characteristics. For example, residents of hospital-based facilities are generally older and more functionally dependent than residents of freestanding facilities. Findings from the final analyses of this project are directed toward reimbursement and regulation policies at both the Federal and State levels. The Yale study is a 1-year project whose objective is to develop a patient classification typology according to resource utilization groups. Final results from this project will be available in September 1982. In addition to the broad utility of the results of the Colorado and Yale studies in enhancing our understanding of the generic relationships between case mix, cost, and quality in nursing homes, they will be directly applicable to specific policy related analyses, as discussed under nursing home costs, quality, and reimbursement.

On the basis of the findings from the nursing home survey and the data collection instruments derived for it, the University of Colorado is conducting a second study. In this 4-year project, it will evaluate nursing home and home health care providers in both freestanding and hospital-based settings. Both cost and quality of care will be assessed under four organizational arrangements. Since this project is in the first year, preliminary results are not currently available. Policy issues to be addressed will include the following: Do the higher costs of hospital-based facilities justify different treatment from freestanding units for reimbursement and regulatory purposes? Is home health care a cost effective substitute for nursing home care for certain types of patients?

A fourth project in this group will collect and disseminate data on long-term care residential facilities for physically disabled individuals. While primarily a data collection effort, the products of this project will provide a wealth of information for further analysis. This project is being undertaken by the University of Minnesota and will gather information on long-term care public residential facilities for physically disabled individuals (e.g., geographic location, number, size, expenditures, rate of admission), demographic characteristics of residents, and services provided. Aside from the data, the project will report on the policy implications of the data collected for planning, evaluation, and improvement of long-term care facilities. The expected completion data for this project is mid-1982.

The two remaining studies in this group are more specific in terms of their focus on specific subsets of long-term care problems and providers. One project is being conducted by the University of Washington and has the primary objective of determining the impact of cost containment efforts by nursing home administrators on the cost and quality of care. A second objective is to study the impact of contextual variables (facility size and external pressures) on administrators' programs to contain costs. This 2-year project will conclude late in 1981. The final study in this group is being conducted by Peter Brigham Hospital in Boston and is intended to devise innovative methods for pricing ambulatory care treatment for patients with hypertension. Reimbursement methods for the medicare and medicaid program will be derived that encourage the most economical and effective long-term management of hypertension. In order to develop these techniques, this project will study the experience of the clinical centers that participated recently in the 5-year hypertension detection and followup program (HCFP). The study will construct profiles of the estimated care required for the effective treatment of hypertension, stratified by age, race, sex, and stage of the disease. To estimate the cost of providing such services under medicare and medicaid, the project will vary assumptions concerning the presence of hypertension and reimbursement mechanisms that might be used.

III. Nursing Home Costs, Quality, and Reimbursement

Research in this area has focused on the following issues: (1) The determinants of nursing home's costs, (2) the effect of State regulations on the supply of nursing home beds, and (3) the effect of reimbursement methods on home's willingness to admit "costly" patients.

This research has shown that in order to make valid cost comparisons among nursing homes, it is necessary to be able to compare the types of patients they treat (case mix) and the quality of care they provide. Hospital research based on diagnosis measures is of limited applicability to nursing homes because of nursing home patient's high frequency of multiple diagnoses and the importance of assistance in activities of daily living. Consequently, basic research is being conducted on methods of measuring case mix and quality of care in ways that can be applied to nursing home policies. Research on two policy issues is discussed in greater detail below.

S. 223 COST LIMITS FOR SKILLED NURSING FACILITIES

Currently medicare sets higher cost limited for hospital-based than for freestanding skilled nursing facilities. Are the large cost differences that we observe between these two types of facilities justified by differences in the costliness of their case mixes? Or do hospital-based facilities just employ a more expensive mix of personnel to treat similar patients? The University of Colorado (grant No. 18–P–97145) and Yale University (grant No. 18–P–97757) are investigating alternative approaches to case mix measurement that will hopefully be useful in explaining differences in nursing home costs. Colorado combines measures of activities of daily living with measures of medical and psychosocial problem severity in making case mix assessments. They also take account of the impact on costs of differences in the quality of care. Their final report is due in May 1982.

Yale is conducting a pilot study to determine the feasibility of defining a patient classification or grouping system related to nursing home resource consumption and costs. Their final report is expected by July 1982.

Another University of Colorado grant (No. 18-P-97712) will apply the measures developed in grant No. 97145 specifically to the question of hospital-based versus freestanding facilities' costs. (This grant will also compare the cost effectiveness of hospital-based and freestanding facilities in providing nursing home and home health care). Preliminary results from this grant will be available by December 1983. The final report is due in February 1985.

DUAL PARTICIPATION BY SKILLED NURSING FACILITIES

Skilled nursing facility services are provided under both the medicare and medicaid programs. In 1980 Congress asked us to investigate why only two-thirds of the skilled nursing facilities that participate in medicaid also participate in medicare. In particular, we were asked to study the impact of laws and regulations in discouraging facilities' participation in both programs and to assess the desirability of requiring dual participation. Research for much of the report was conducted by the Urban Institute under grant No. 18-P-97727.

The research found that many States provide broader, longer term medicaid benefits than does medicare. Medicare covers only a small part of the nursing home population for very short-term convalescent care. Administrative differences between the programs, especially in reimbursement methods, also discourage facilities' participation in medicare. The report, scheduled for delivery to Congress by January 1982, attempts to both acknowledge the critical differences between the programs and to make them more compatible where that is feasible.

IV. Mental Retardation/Developmentally Disabled (MR/DD)

Expenditures for services provided in intermediate care facilities for the mentally retarded (ICF/MR) are growing rapidly under the medicaid program. While the mentally retarded and developmentally disabled population has remained relatively stable, expenditures for this group have grown by approximately 800 percent over the past few years to an estimated $2.1 billion in fiscal year 1980. Information about coverage, eligibility, cost, and utilization of services by the MR/DD population under medicaid is required so that we can understand the reasons for the phenomenal growth of the cost of this care and design medicaid policies in the future which provide appropriate care to those who need it while containing costs. It is also important to assess the effects of deinstitutionalization of the MR/DD population particularly with respect to medicaid and to determine the role medicaid plays in the overall system of care for the MR/DD population.

A grant to the University of Minnesota's psychoeducational studies unit entitled "Collection and Dissemination of Nationwide Data on Long-Term Care Residential Services for Developmentally Disabled People, 1981–1984" fits in this area. This project will update a national information system on long-term care services for the MR/DD population. Included in the system will be information on licensed long-term care facilities, including certified ICF/MR facilities. National surveys of residential facilities and State statistical offices will also be conducted to monitor trends in the deinstitutionalization of this population group. Data will be gathered on the size, number, geographic location, ownership, and costs of care. Resident admission, readmission, and discharge data will also be compiled. A significant part of this project will be policy studies which address issues directly related to medicaid coverage, costs, eligibility, and utilization. Results are due in early 1984, although various policy studies will be completed before that time.

Also, a survey of State medicaid officials' policies regarding ICF's/MR is being conducted as part of an ongoing HCFA grant to the intergovernmental health policy project at George Washington University. Previously this group surveyed State mental retardation/developmental disabilities officials and other knowledgeable State officials about ICF's/MR. The results of this new information gathering effort are due early in 1982. This will provide some general information on States' activities during 1981 useful for policy formulation.

LONG-TERM CARE DEMONSTRATIONS—OVERVIEW

Our current demonstration activities are focused in four major areas of investigation—*management* of the mix of long-term care services provided; the *types* *of services* provided; *reimbursement* for services; and, streamlining the *survey and certification* process. Although many of our projects address more than one area, the following examples of each area are categorized according to their primary focus. For a more complete description of our demonstration activities, project summaries, and current findings follow this section.

I. Management

The coordination and management of an appropriate mix of health and social services directed at individual client needs is hypothesized to reduce institutionalization and costs without sacrificing quality of care.

HCFA funds a number of community care projects (Mt. Zion, ACCESS, On-Lok, etc.) which include such common elements as case assessment, care planning, and case management. Evaluations of these projects are providing preliminary data regarding the impact of these management techniques on client characteristics, costs and utilization of services, and client outcomes.

In September 1980, the Department announced implementation of the national long-term care demonstration program. Program responsibility for this effort is shared by ASPE, HCFA, and AOA. Twelve States were awarded contracts to conduct "channeling" demonstrations—experiments involving assessment and case management.

These projects utilize a common assessment instrument and evaluation design and provide payment for a few additional services beyond those currently available under Federal programs.

II. Types of Services

Medicare and medicaid coverage of long-term care services is restricted to services primarily medical in nature and is restricted to provision of such services in specific settings. It is hypothesized that payment for certain quasimedical services, or changes in the location of services, can reduce the overall costs of long-term care.

During fiscal year 1980, HCFA implemented the hospice demonstration project which permits the waiver of certain statutory and regulatory requirements in order to allow coverage of hospice services provided to medicare beneficiaries and medicaid recipients. Participating hospices may be reimbursed under the demonstration for a number of items and services not currently covered by medicare and medicaid. Examples include: Outpatient prescription drugs, institutional respite and home respite services (primary care giver relief), visits by dieticians and homemakers, supportive and counseling visits to hospice patients during occasional hospital stays, continuous care (by nurses, home health aides, or homemakers) on a shift basis in the home, certain self-help devices, inpatient hospice care, and bereavement services to family members.

Twenty-six organizations have been selected for participation in the project, based on the need for evaluation data that would reflect urban and rural differences and variations in hospice provider types.

The Departments of Housing and Urban Development (HUD) and HHS are jointly funding a demonstration to test whether the chronically mentally ill can be deinstitutionalized and integrated into the community by providing housing support and medicaid coverage of services such as life skills, transportation, and supervision.

III. Reimbursement

Innovative reimbursement methods, including competition-based models, are being tested to determine whether they reduce costs without adversely affecting patient outcomes.

In the Social HMO project, the concept of providing a continuum of medical and health services to an elderly population, within an HMO context, is being tested by Brandeis University. The activities that will take place in this 3-year project are the development of a demonstration and evaluation protocol for the Social HMO concept, the selection of and developmental assistance to three sites, and the implementation of the Social HMO demonstration.

IV. Survey and Certification

Scarce surveyor time is being reallocated to test the impact of changes in the current survey and certification methods for determining quality of care in long-term care institutional settings.

Projects in Wisconsin, Massachusetts, and New York, are currently underway which streamline the nursing home survey and certification process.

In Wisconsin and New York, the goal is to move from a single "paper review" of patient care and a facility's ability to meet Federal/State standards to a screening approach which focuses surveyor time on the actual care provided to patients and the facility's ability to provide that care.

While the Massachusetts project does not change the current medical review (MR)/independent professional review (IPR) requirements, it does concentrate surveyor time on identifying nursing homes which have had difficulty complying with Federal/State conditions of participation.

It is anticipated that findings from these three projects will be instrumental in the development of more effective nursing home survey and certification methods in which surveyor time is better utilized.

LONG-TERM CARE DEMONSTRATION PROJECT SUMMARIES

Coordination and Management

Triage (Connecticut).

Cost-effective alternatives to nursing home institutionalization (Georgia).

Monroe County demonstration of a communitywide alternative to long-term care/medicaid (New York).

A continued demonstration of the community long-term care center through inclusion and expansion of title XVIII (New York).

Delivery of medical and social services to the homebound elderly: A demonstration of intersystem coordination (New York City).

Evaluation of New York State's long-term home health care program.

Multipurpose senior services project (California).

Long-term care demonstration design and development. Mr. Zion (California).

Long-term care project of north San Diego County (California).

FIG waiver continuum of care project for the elderly (Oregon).

South Carolina—community LTC project: Demonstration to direct State policy for long-term care.

Ancillary community care services: A health care system for chronically impaired elderly persons (Florida).

Modification of the Texas system for care for the elderly: Alternatives to the institutionalized aged.

Colorado medicaid physician nursing home project.

National long-term care demonstration: Pennsylvania, Texas, Hawaii, Maine, Kentucky, and Maryland.

Medicare and Medicaid Coverage

Medicare and medicaid hospice demonstration.

HUD/HHS demonstration for deinstitutionalization of the chronically mentally ill.

Experiment to waiver the 3-day prior hospitalization requirement for medicare coverage in skilled nursing facilities (Massachusetts and Oregon).

Innovative Reimbursement Methods

A social/HMO program for long-term care.

On Lok senior health services: A community care organization for dependent adults (California).

California skilled nursing pharmacy services—capitated reimbursement experiment.

West Virginia standard appraisal value nursing home reimbursement demonstration.

California nursing home incentives project.

Survey and Certification

Service-by-exception (Massachusetts).

Improving New York State's nursing home quality assurance program.

Wisconsin quality assurance project.

Connecticut, Triage: Comprehensive, Coordinated Care of the Elderly

The Triage model is based upon a single entry access point to the health delivery system for elderly persons. The demonstration project tests the feasibility and effectiveness of service coordination for elderly and disabled individuals living in a seven-town area in central Connecticut. The project is designed to build an appropriate interface between client and multiple service agencies, whereby care is organized around the client and the available resources.

Triage was initiated by the State of Connecticut in 1974, with State funding and a grant from the Administration on Aging and in 1975 received section 222 medicare waivers together with funding from the National Center for Health Services Research, Public Health Service, for the research component of the project. These initial years of the project are referred to as Triage I.

On April 1, 1979, HCFA approved a 2-year project utilizing the same demonstration and research design in order to obtain needed longitudinal data regarding the utilization and cost of services provided to this group of patients from the inception of the project. This 2-year project is known as Triage II.

The project is targeted at an eligible population of 19,526 people, 65 years and over who are entitled to medicare parts A and B. The service delivery system has been developed around individual needs rather than tailoring the care to existing reimbursable sources. The delivery model includes the following features: Patient assessment and individualized plans of care; coordination of all available health related services; creation of new services in the demonstration area; monitoring of the plans of care; and evaluation of pertinent data in accordance with a research design so that patient outcomes and costs of services can be available for study by health care planners.

The project serves a caseload of 1,500 parttiċipants.

The objectives of the project are:

(a) To increase effectiveness of health services.

(b) To develop necessary preventive and supportive services and demonstrate their value to target population.

(c) To provide single entry assessment mechanism to coordinate delivery of institutional, ambulatory, and in-home services which will result in cost containment.

(d) To demonstrate the effectiveness of coordinated care, including: (a) Care to prevent illness, compensate for disability and support independent living at home; (b) care prescribed appropriate to need rather than according to third-party payer service restrictions; and (c) use of professional nurse-clinician/social service coordinator teams to assess needs of individuals, arrange for appropriate services and provide case management services.

(e) To reduce expenditures for health care delivered to target population.

The Triage model operates through a clinical process of care developed and monitored by interdisciplinary teams, each of which consists of a nurse-clinician and a social service coordinator (social worker). The clinical process of care includes the following four stages:

(a) *Referral.*—Most frequent sources of referral have been self-referral, family, friends, visiting nurses, hospital discharge planners, physicians, and social workers.

(b) *Assessment.*—The nurse-clinician/social service coordinator team jointly visits the client's home to fully assess client needs, using a comprehensive assessment form. This form was developed and refined by project clinical staff, the project research team, and a geriatric physician consultant. The assessment consists of a modified physical examination, and an extensive interview. The interview includes a complete health history, information on client functional status, nutrition, physical environment and informal support system. Functional status is assessed by the use of three standardized instruments—the Activities of Daily Living (Katz, et al.), the Instrumental Activities of Daily Living (Lawton and Brody) and the Mental Status Questionnaire (Goldfarb, Kahn, et al). This process provides the data base upon which the plan of care is developed for each client.

(c) *Coordinating the care plan.*—Based on the assessment data, a plan of care is developed. The Triage team works with the client and his or her family to select services appropriate to the client's needs and the providers that will be asked to deliver the authorized services.

(d) *Monitoring.*—After-service delivery commences, the Triage team maintains ongoing contact with the client to assure that services continue to be consistent with the care plan, in terms of quality and quantity. In addition, the team consults frequently with providers and meets on a monthly basis with home health agencies in the region and other providers as neeeden. A medical-dental advisory committee is available to Triage staff for consultation and review of client status. The committee consists of five physicians (with different specialties), two dentists, a podiatrist, and a pharmacist.

The section 222 medicare waivers have made it possible for Triage to authorize payment for many ancillary and supportive services not traditionally covered by medicare, and to waive specific medicare requirements such as coinsurance and deductibles and restrictions on home health care.

The following table identifies the services available to Triage clients, including waivered services and traditional medicare services.

Service category	Traditional medicare services	Waivered services
Institutional	Hospital, skilled nursing facility	Intermediate care facility, home for the aged, day care.
Home care	Visiting nurse, home health aide	Homemaker, chore, companion, meals and meal delivery.
Ambulatory	Physician, outpatient service diagnostic services (X-ray and laboratory), therapies (speech, physical, occupational), dentist (selected medical conditions), podiatrist (selected medical conditions).	Optometrist, dentist (routine and preventive), podiatrist (routine and preventive) mental health counseling.
Products	Medical equipment, supplies	Pharmaceuticals, hearing aids, glasses.
Transportation	Ambulance	Chair car, taxi.

Traditional medicare services are reimbursed according to the procedures and rates of that program. For other services not normally included under medicare, the method of reimbursement varies according to service type. Homemaker and ICF's for example, are reimbursed on a cost-reporting basis; pharmaceuticals and optical care are reimbursed using medicaid rates established by the State Department of Social Services. For other services, Triage obtained schedules from government and industry sources (e.g., Connecticut Public Utilities Commission rates used for transportation). Rates were negotiated with each provider for services and as meals and meal delivery, companions, and chore service.

Triage has provided training opportunities for providers and students in health professions programs throughout the life of the project.

Data from Triage I are currently being analyzed by NCHSR. Findings from the initial years of the project, funded under the auspices of PHS, should be available in fiscal year 1981. Preliminary data from Triage I indicate that: 72 percent of participants improved or maintained their ADL (activity of daily living) and MSQ (mental status) scores. However, the overall performance of the participant group on assessment scores decreases with advancing age. The total cost per participant for 1978 was $3,620 or an average per diem cost of $12.63 per day. Data from Triage II is not available, as the project will not terminate until the end of fiscal year 1981.

Triage II was terminated at the end of fiscal year 1981, however waivers and grant funds are to be continued until December 31, 1981, to allow the project to complete the termination phase of the project.

Georgia, Alternative Health Services

In July 1976, under the authority of section 1115 of the Social Security Act, the Georgia Department of Medical Assistance embarked on a demonstration project in 2 of the 10 districts designated by the Georgia Department of Human Resources (covering 17 counties). The project offers alternative services to nursing home care for persons who would otherwise be placed in institutions. The model is built on a centralized single point of entry into all service systems. In addition to regular medicaid financed health services, the demonstration offers three alternative services; adult day rehabilitation, home-delivered services and alternative living services (e.g., personal care, adult foster care, boarding services, and congregate living arrangements). By the end of June 1980, intake for the research and demonstration was completed. The program had assigned 1,229 clients to the experimental group and 384 clients to the control group. The active caseload included 566 experimental clients. Following this period, control clients were allowed to become program participants and by June 1981 there were 630 active clients receiving program services.

All potential alternative health services (AHS) clients receive a health and social needs assessment prior to enrollment. Along with self-referrals, the project receives referrals from hospitals, the County Department of Family and Children Services and the Georgia Medical Care Foundation, the project's independent utilization review contractor. Clients who appear to be eligible for services are interviewed by designated caseworkers from the county who administer the client assessment interview which collects health and social information on the client. Following the interview, the caseworker obtains the relevant medical data from client's physicians and additionally significant social information on family and support systems. The information gathered by the caseworker is reviewed at a team conference consisting of an AHS nurse and social worker and designated caseworker. The team uses the State maximum units of service guidelines to identify patients who require more intensive care than the project can provide. After the conference, the caseworker notifies the client of service recommendation or control assignments. (Three out of every four clients determined appropriate for the project are randomly assigned to AHS service groups with the fourth assigned to a control group. Clients in both groups are tracked for the duration of the project.)

Once a patient is accepted to participate in the project he or she is referred to appropriate providers. A face-to-face interview is conducted by the provider who notifies the team within 5 days whether or not the services recommended are adequate for the client. The provider then indicates the services to be offered, the frequency of services and provides a justification for not providing services recommended by the assessment team. Any changes in the client's care plan must be approved by the team. Once services are initiated, both a case manager and case coordinator work to assure the continued provision of services which are appropriate to meet the client's needs.

Standard contracts have been negotiated with a large number of alternative services providers which include: (1) Prior agreement on specific expenditures and cost allocations; (2) a line item budget which the provider cannot exceed; and (3) a system which allows a provider to retain unexpended funds for use in program expansion.

The following highlights some of the preliminary cost and utilization findings from the first operational year. Analysis of data from subsequent years may change these findings:

Total medicaid mean monthly costs for the experimental group are 76 percent higher than for the control group. Medicaid costs exclusive of AHS costs for the experimental group, however, are 9.4 percent less than for the control group. The most significant differences by category of expenditure are for nursing home, inpatient hospital and physician costs.

—Medicaid nursing home costs are on the average $15.94 per month or 38 percent higher for the control group than for the experimental group.

—Physicians costs reimbursed by medicaid are 141 percent higher for the control group than for the experimental group.

—Mean medicaid inpatient hospital costs for the experimental group are 49 percent higher than for the control group. These cost figures are consistent with the finding that individuals in the experimental group utilized an a verage of 5.4 hospital days during first year of enrollment as compared with clients in the control group who used 4.1 hospital days on the average. This finding may be attributed to the professionals who provide AHS services and recognize the need for hospitalization before it might otherwise be recognized by the client or the family.

The utilization and service cost figures indicate that 42.6 percent of the clients have received home-delivered services, 14.7 percent have received adult rehabilitation services, and 2.8 percent have received alternative living services. The mean monthly project service costs per person of home-delivered services was $129, adult day rehabilitation $216, and alternative living services $212.

The final project report is expected November 1981.

During the 1980 Georgia General Assembly session, the Department of Medical Assistance was granted the authority to expand the AHS program so that it may be adopted statewide. AHS program services will be phased into new areas of Georgia through a 3-year statewide expansion process. The State expects the program to be fully operational by 1984. For the demonstration phase, the project had operated in two of the State's area agencies on aging districts. As part of a competitive bidding process, five additional agencies have been selected to expand the delivery of services. In preparation for statewide implementation, the program is establishing ongoing linkages with providers and agencies. The project has been streamlining its systems by developing a computerized system for prior authorization, modifying AHS provider manuals, developing new invoicing procedures, and revising forms.

Evaluation.—An evaluation of the project is being undertaken by Medicus Systems Corp. under contract to the grantee. Medicus has participated in and reviewed all aspects of the project including the technical research aspects and the management system. In particular, the evaluation will focus on costs, utilization, health impact, and effectiveness. This evaluation will be included in the final project report. Berkeley Planning Associates will conduct a secondary evaluation of this project as part of the HCFA crosscutting evaluation.

New York, Monroe County I

The New York State Department of Social Services is conducting a demonstration project under the authority of section 1115 of the Social Security Act, through the Monroe County Long-Term Care Program, Inc., (MCLTCP). The purpose of this project is to demonstrate alternative approaches to delivering and financing long term care to the adult disabled and elderly medicaid population of the county.

The project has developed the assessment for community care services (ACCESS) model as a centralized unit responsible for all aspects of long-term care for Monroe County residents, 18 years of age or older, who have long-term health care needs, and who are eligible for medicaid benefits. Program responsibilities include developing and coordinating community services, administering long-term care funds, approving all public payments for institutional and community long-term care services, and collecting program data. ACCESS staff provides each client with a comprehensive needs assessment, assistance in planning and obtaining community or institutional services, and ongoing monitoring of the appropriateness of the services. All long-term care services provided under medicaid in the county must be coordinated with the ACCESS unit in order for the provider to be reimbursed. Private pay patients may voluntarily use ACCESS services.

ACCESS assessment activity varies based on client location (e.g., acute care facility or in the community). However, actual assessments are all carried out by using the preadmission assessment form (PAF) developed by the project to improve upon previously utilized State forms which attempted to document patient condition. The principal focus of the PAF is to determine client's capacity for self-care and to determine specific service needs necessary for the patient to remain at home, if at all possible. Assessments are carried out by Community Health Nurses (CHN) from the County Health Department or the Visiting Nurse Service of Rochester (VNS).

Once a patient's needs have been determined, the assessor completes an alternate care plan (ACP) form which provides a detailed home care package, including identification of service, personnel needed, and equipment necessary for home care. On the basis of the ACP, ACCESS determines the cost and practicality of home care for the patient. If the patent and family agree to the service plan, steps are taken to initiate services for the client (whether it involves home care or admission to a long-term care facility). As part of its contract with the County Division of Social Services, ACCESS may only approve home services for medicaid clients who can be assisted in home care for less than 75 percent of the cost of a comparable level of care in a long-term care facility. If costs exceed 75 percent, ACCESS must make a special request to the DSS to allow home services. Nonmedicaid patients (e.g., private pay voluntary participants) must arrange for payment of their services on their own, although ACCESS will assist and advise them in these arrangements.

ACCESS provides followup to its client population by a home review system. Home review visits are made three times a year for medicaid clients and where necessary and agreed to by nonmedicaid clients.

Utilization review forms are routinely shared with ACCESS by three church-sponsored nursing homes and one public facility in the county for all required review periods (i.e., 30-, 60-, and 90-day review) which determine whether the patient is at the appropriate level of care. If the UR form indicates a change may be necessary, the Genesee Valley Medical Foundation (which conducts the utilization reviews) transmits the form to ACCESS for review and resolution.

Section 1115 medicaid waivers permit the project to include the following services: Friendly visiting, housing improvement, home maintenance/heavy chore services, housing assistance, transportation, moving assistance, and respite care.

The project has the authority to contract with providers for the delivery of certain services. After bills are submitted to the project by providers, their claims based on State medicaid reimbursement schedules are forwarded by the project to the State medicaid office for payment.

Objectives

The objectives of the project are:

—To provide long-term care services which are appropriate, cost-effective, and acceptable to the client.

—To provide coordination and continuity of case management for long-term care clients.

—To improve long-term care assessment and review procedures.

—To collect data about needs, service utilization, and appropriateness of placement of persons requiring long-term care.

—To reduce the number of county residents who are in acute hospitals and long-term care institutions.

—To reduce per person rate of increase of medicaid expenditures for individuals needing long-term care below the rate that would have occurred had the project never existed.

In the initial 32 months of ACCESS activity, 8,862 referrals were received; 4,766 from hospitals and 4,096 from community sources. The community referrals came from home health agencies (33 percent), clients and/or families (28 percent), long-term care facilities (10 percent), local human services agencies (4 percent), and physicians (5 percent).

The percentage of community medicaid patients resolved at home has increased over the life of the program. During the first year of operation, 88 percent of the medicaid patients referred from the community were resolved at home, but in 1980 (through July) 96 percent of community medicaid patients were resolved at home. Increases have also been dramatic for nonmedicaid community patients who, in 1978, had only 75 percent home resolutions, increasing to 88 percent in 1980. Similarly, more hospital patients have been resolved to home care since the start of the program. During the first year, 35 percent of the medicaid patients referred from the hospital were resolved at home. In 1980 (through July) 54 percent were resolved at home. For nonmedicaid patients in 1978, 18 percent were resolved at home while in 1980, 25 percent had home resolutions.

Medicaid costs for all direct, noninstitutional services for the 1,123 skilled-level patients who were assessed at home under the ACCESS system, are estimated to be $25.12 per day, or 52 percent of the comparable medicaid institutional rate (at $50 per day). The medicaid costs for health related and proprietary home level service packages are also reported to be less than half of the comparable institutional rate.

Preliminary data show that home care costs for long-term care patients under the demonstration are from 30 to 50 percent of the county's comparable institutional costs. Skilled nursing services provided in the home through the project were estimated to be $22.22 per day compared to $50 per day for equivalent institutional care. For health-related services (equivalent to ICF care), the costs were $9.29 for home care as compared to $30 for institutional care. At the domiciliary care level, the costs were $3.74 compared to $16 at the institutional level.

The project has been continued for a seventh year as a waiver only, primarily to test the effectiveness of a single organizational management structure for both medicaid and medicare participants (see Monroe II for description of 222 project).

Berkeley Planning Associates will conduct a primary evaluation as part of the HCFA crosscutting evaluation.

New York, Monroe County II

The delivery model used for the section 1115 Monroe County long-term care medicaid project (Monroe County I) will be expanded under the authority of section 222 of the Social Security Act to include care management and patient assessment services for the county's medicare population in need of long-term care. This demonstration shares the purposes and goals of the section 1115 medicaid project. The addition of this project to the Monroe County program will enable the county to work toward an integration of medicare and medicaid long-term care services in the county and to simplify program administration.

In addition to the ACCESS process described for the Monroe County I project, section 222 medicare waivers will enable this project, approved in July 1980, to implement a utilization review component whereby once a client has entered a facility or has been approved for home care, a set review schedule will be used. Medicare-entitled clients will be reviewed in a skilled nursing facility every 14 days by a utilization review nurse from the Genesee Valley Medical Foundation. Medicare-entitled clients at home will be reviewed by a nurse from a certified home health agency every 28 days. In addition, the section 222 medicare waivers will permit ACCESS to certify a client's need for skilled nursing services for up to 14 consecutive days in a skilled nursing facility, and up to 28 days for the provision of home care services, if approved by the client's private physician.

The waivered medicare services under this demonstration include: Client intake and assessment; noninstitutional skilled nursing facility services; financial counseling; in-home architectural review; and transportation services. Extended care services will be furnished to participating skilled nursing facilities (SNF's) if the patient requires daily skilled nursing or other skilled rehabilitation services which can only be provided in a SNF on an inpatient basis. The "posthospital" medicare requirements for SNF care and part A home health care are also waived in order to implement this project.

This project is scheduled to begin operations in March 1982.

Berkeley Planning Associates will conduct a primary evaluation as part of the HCFA crosscutting evaluation.

New York City, Delivery of Medical and Social Services to the Homebound Elderly

The New York City Department for the Aging is conducting a 3-year medicare demonstration of the delivery of medical and social services to the homebound elderly, under section 222 of the Social Security Act. A separate grant from the Administration on Aging is supporting certain administrative activities and supplemental service delivery costs for the project.

The purpose of the demonstration is to test a community-based methodology which will provide a spectrum of medical and social services, directly and by linkage and coordination, to a homebound chronically ill population. Specifically, the project is targeted to persons aged 65 and over entitled to medicare part B who suffer from chronic illness, functional or mental impairment, and who are unable to visit a physician without assistance or have no access to medical care.

Four sites have been developed, each serving 100 individuals (totaling 400 participants for the project) with a comparison group of 200 for research purposes. The project's major objectives are threefold:

(1) Identify characteristics of this population, needed levels of care, costs of delivering such care, and the effect of care delivery.

(2) Demonstrate the process of coordination, and identify mechanisms and strategies effective in achieving coordination; and

(3) Develop a cost-effective model of coordinated service delivery to be incorporated into the city's system.

A coordinating model has been established to carry out the project, composed of separate organizational components, each with specific responsibilities related to coordination and service delivery. These components include a project advisory committee which is comprised of relevant city departments and four neighborhood-based service delivery sites. The project advisory committee reviews policy, selects sites, and establishes criteria for clients and services. The committee is also responsible for facilitating agreements between service providers. The neighborhood-based sites conduct centralized intake, assessment, care planning, reassessment and monitoring, conducted by an interdisciplinary team (e.g., nurse and social worker.)

Community-based physicians provide medical consultation to the sites on care planning and signoff on care plans for those clients who do not have their own private physicians. Each consulting physician will spend 1 full day each week at the respective site and will be available for special assessments.

The project has developed the four sites incrementally; two became operational in December 1980, and the other became operational in June 1981. The four sites are:

—Sunset Park Family Health Center (Brooklyn) which is part of Lutheran Medical Center (but functions as a freestanding clinic).

—Community Agency for Senior Citizens which is sponsored by the Staten Island Home Care Integration Service Coalition and funded under Older Americans Act, title III–B.

—Jamaica Service Program for Older Adults (Queens) which is a voluntary social service agency providing a broad range of services to the elderly in this borough, including services funded under title III–B of the Older Americans Act.

—The Comprehensive Family Care Center (Bronx) which is sponsored by the Albert Einstein College of Medicine.

The four sites may provide services directly, contract for, or arrange for other services in their respective catchment areas.

Services provided through the medicare waivers are the core around which other community services will be obtained for project clients. These services are: Homemaker, personal care services, transportation and escort services, and drugs and biologicals.

The assessment instrument is based for the most part on the Georgia Alternative Health Services "client assessment interview" together with the New York State DMS–1 medicaid preadmission instrument.

Evaluation.—The project is included in the HCFA crosscutting evaluation which is being conducted by the Berkeley Planning Associates.

New York State, Long-Term Care Home Health Care Program—Nursing Home Without Walls

The New York State Long-Term Home Health Care Program (LTHHCP), also known as the "nursing home without walls" program, was established by the State legislature to become effective April 1, 1978. The program provides an alternative to institutionalization for medicaid clients who meet the medical criteria for skilled nursing facilities (SNE's) or intermediate care facilities (ICF's). A maximum expenditure for home care has been set at 75 percent of the going rate in a locale for SNF or ICF levels of care for which the client is eligible.

The New York State Department of Social Services received medicaid waivers in September 1978, under section 1115 of the Social Secuirty Act to assist in a 3-year demonstration of the gradual implementation of the program.

The purpose of the program is to reduce fragmentation in the provision of home care services to the aged and disabled through a single entry system which coordinates and provides these services in (currently) 11 sites throughout the State. The sites are based on a single entry system which coordinates and provides all of the services. The objectives of the project include: (1) Maximizing the use of available resources; (2) determining whether various types of providers are differentially successful in providing these services: (3) comparing the effectiveness of long-term care programs in different geographical areas; (4) comparing the program with traditional home health care provided by certified agencies; and (5) promoting cost containment.

As illustrated below, each of the 11 active sites show a different pattern in development of their respective patient caseloads.

Sites	Operational Date	Current caseload[1]	Capacity
Bronx: Montefiore Hospital	August 1979	101	100
New York City: St. Vincent's Hospital	September 1979	49	80
Queens: Visiting Nurse Service	May 1980	80	75
Brooklyn: Metropolitan Jewish Geriatric Center	May 1979	159	150
Buffalo: 24 Rhode Island St. Nursing Home	November 1978	52	50
Buffalo: Erie County Department of Health	September 1979	100	100
Syracuse: Visiting Nurse Association of Central New York	March 1979	52	100
Syracuse: Onondaga County Department of Health	March 1979	95	125
Olean: Cattaraugus County Department of Health	April 1979	14	25
Troy-Eddy Memorial Foundation	May 1981	16	25
New York City: Jewish Home and Hospital for the Aged	September 1981	1	100

[1] Current caseload as of Sept. 28, 1981. New York State regulations allow sites a 10-percent allowance factor to the approved capacity rate for hospital patients who will return to the program.

Under the LTHHCP, all patients must be medically eligible for placement in a residential health care facility. For all potential program users, a medical assessment abstract must be completed which produces a predictor score, referred to as the DMS–1 score. The DMS–1 assessment instrument is used in New York State as a tool to determine the appropriate placement of patients in long-term care facilities. When patients are determined to be eligible for the LTHHCP program an in-home assessment is completed by a LTHHCP nurse and a caseworker from the local social service district. Following completion of the assessment, a plan of care is developed and a budget review is initiated by the caseworker. This budget review determines whether the total projected costs are within 75 percent of the monthly average medicaid costs of the going rate for SNF or ICF levels of care for which the client is eligible. A reassessment is conducted every 120 days and a physician review of patient care needs is renewed every 60 days.

The coordination of the services and the case management functions are shared by the LTHHCP coordinator and caseworker. Professional support must be available to patients through an emergency on-call system 24-hours a day.

In the initial startup phases, the State Department of Social Services and Health Systems Management, together with State Senator Lombardi (the author of the LTHHCP legislation), met with local commissioners in each district site to familiarize them with the program and facilitate program implementation. In addition, the State met with hospital discharge planners to make them aware of the program and worked with the local social service districts to train staff and provide technical assistance to the LTHHCP staffs. However, the project experienced some difficulties in becoming fully operational. Startup was delayed as a result of staff turnover, problems in coordination, and site difficulties in obtaining referrals. There was also a delay in the enactment of State legislation authorizing financial participation for reimbursement of the seven waivered services under the section 1115 demonstration authority. The implementation guidelines for paying these waivered services became effective in September 1980. The waivered services are: Home maintenance, nutrition counseling/educational services, respiratory therapy, respite care, social day care, transportation, congregate meal services, moving assistance, housing improvement services, and medical-social services. The rates for the waivered services were approved on June 1, 1981.

The project has acted to resolve some of its earlier problems with three additional State monitoring staff positions to provide site assistance and to work with the evaluator in coordinating and developing the data collection strategy. Because there have been delays in the joint assessment process to determine patient eligibility, an "alternative entry procedure" was established which allows the provider to begin service to the patient immediately based on their own initial assessment of the patient. A joint assessment is then conducted with the local social service district.

In the New York City area, where there are four sites, a long-term care task force was established in 1979 with participation from the sites and the New York City Human Resources Administration to facilitate communication and coordination of efforts in program implementation.

The following legislative modifications passed by the State legislature in June 1980 enabled the program to expand its client population and improve operations: (1) Reallocation of slots among nine sites; (2) passage of a senate bill to annualize the 75-percent cap so that if it is reasonably anticipated that average expenditures for a year's time will not exceed the cap, the patient can be admitted to the program.

In 1980, the New York State Department of Social Services received supplemental funding to support the collection of primary data on comparison patients. This data will be analyzed and used in the HCFA project evaluation conducted by Abt Associates, Inc. The State appointed a data coordinator and hired and trained 31 data collectors. The State has also finalized agreements with facilities to participate in data activities. The data collection began in April 1981. To facilitate the collection of data, the State has recruited additional data collectors. The data coordinator is working with Abt Associates to make necessary revisions in the data collection instruments.

By September 28, 1981, the State approved eight additional long-term home health care programs. These additional programs result in a total of 19 LTMMCP's with an approved capacity of 1,500. Six of the already operational sites have applied or are considering applying for an increase in their approved capacity rates. The rates for the varied services were approved in June 1981. All of the operational sites are providing or establishing a mechanism to implement the services.

In August 1981, New York State passed legislation to allow proprietary hospitals and nursing homes to apply to become long-term home health care programs. An amendment was also passed to permit providers to bill at the medicare rate for private pay patients for all services. Previously, all services for private pay clients were billed at the medicaid rate.

Evaluation.—Abt Associates is conducting the primary evaluation of the program. This evaluation consists of two major components: A descriptive analysis of the development, organization, administration and impacts of the LTHHCP, and a comparative analysis of the LTHHCP with traditional home care to determine cost, utilization, and patient outcomes of the LTHHCP. The evaluation of the program will focus on the initial nine program sites. Berkeley Planning Associates will conduct a secondary evaluation as part of the HCFA crosscutting evaluation.

California, Multipurpose Senior Services Project (MSSP)

In September 1977, the State legislature enacted AB998, which required the State Health and Welfare Agency to establish MSSP across the State that would test single entry access to the health and social services system through case management, care planning, and needs assessment. In October 1979, the State Health and Welfare Agency received a "waiver-only" grant under section 1115 of the Social Security Act to implement the State-mandated MSSP demonstration over a 4-year period.

The demonstration is being implemented in eight sites across the State. Some of the sites provide services directly while others are limited to case management and purchase of service functions. All sites have the authority to contract for services with local providers.

The target population for this project is persons aged 65 and over who are considered at risk of institutionalization and who meet the State eligibility requirements for Medi-Cal (medicaid). There are 1,900 participants in the MSSP; 2,300 comprise the comparison group sample. The project caseload is drawn from Medi-Cal eligibles from the community, acute care hospitals, and from skilled nursing facilities (SNF's).

The project has received medicaid waivers to provide certain health-related and social services which are not otherwise provided under the State Medi-Cal program. These include: (1) Adult social care; (2) housing assistance; (3)in-home supportive services; (4) legal services; (5) nonmedical respite care; (6) nonmedical transportation; (7) meal services; (8) protective services; (9) specialized communication; and (10 preventive health care.

Other services are being provided from existing State funds under titles XIX and XX of the Social Security Act and title III of the Older Americans Act, as well as the State general fund.

The demonstration has both comparative and operational objectives. The comparative objectives are: To reduce client's number of hospital days, to reduce client's number of SNF days, to reduce total expenditures of social and health services for clients, and to improve/maintain client functional abilities.

The operational objectives are: To estimate effectiveness of existing services, to estimate and compare among sites the most effective mix of LTC services, to estimate optimal expenditure for client care while reducing SNF and hospital patient days, and to estimate optimal expenditure for client care while improving or maintaining client's functional abilities.

Individual sites were required to meet specific State MSSP prescribed criteria before becoming operational. As of September 1, all eight sites were operational. (The State project became operational in March 1979.) The sites have phased-in caseloads and staffing at a MSSP prescribed pace. The project had reached full caseload by April 1981. The eight sites are:

—Jewish Family Services, Los Angeles.
—East Los Angeles Health Task Force.
—Senior Care Action Network, Long Beach.
—Mount Zion Hospital and Medical Center, San Francisco.
—City of Oakland.
—Greater Ukiah Senior Citizens Center.
—County of Santa Cruz.
—San Diego County Area Agency on Aging.

During the first developmental and preoperational year several major tasks were carried out. A public relations campaign was launched to inform key State and local officials and agencies about MSSP. Comprehensive planning was conducted at the site level with State MSSP involvement. Staff for the State and each site were hired, and during the months of March, June, and August all sites were trained by the State on all aspects of local MSSP operations. A comprehensive training protocol was prepared for this activity.

A uniform patient assessment instrument has been developed and pretested, and finalized for use at all eight sites. This comprehensive assessment instrument is conducted in two parts—social assessment and medical assessment. It is administered by a nurse practitioner and a social case worker, respectively. The instrument is currently being refined further based on experience at the sites to date.

MSSP has developed the data collection procedures for the participant's information, designed a system to analyze the effectiveness of the program, and designed a computerized management information system. The computerized MIS will be operational by April 1981. Project data that has been processed manually (since becoming operational) will be transferred to the computerized system in April.

During the 02 project year, the sites completed staffing and caseload acquisition at a MSSP prescribed pace. All sites were at full caseload by April 1981. Progress during the second year has been excellent.

Evaluation.—During year 02, MSSP engaged in intensive startup and implementation activities related to the evaluation of the project. Progress to date has been excellent. By the end of year 02, all of the necessary research components will be in place and operational. These components include a computerized management information system with all sites equipped with interactive terminals for local data entry and printers for programmatic and administrative reports, an analytic group staffed at the University of California, Berkeley, and a survey team with 90 percent of the control sample acquired. In addition, Berkeley Planning Associates will conduct an evaluation as part of the HCFA crosscutting evaluation.

San Francisco, Mt. Zion Hospital Long-Term Care Demonstration Design and Development

The Mt. Zion Hospital and Medical Center is conducting a medicare demonstration under section 222 of the Social Security Act to implement a hospital-based long-term care services delivery system in a designated service area. This model builds upon components of Mt. Zion's existing geriatric services, including acute care, emergency health services, outpatient services, home care and information and referral. A consortium of five service providers under the direction of Mt. Zion will cooperate to provide a range of health and social services to the frail elderly in the designated catchment area. The demonstration was originally scheduled to last for 3 years. A fourth year, from June 30, 1981 through June 29, 1982, was recently approved to give the project an additional year to derive research findings.

The project is providing centralized intake and case management, including assessment, care planning, and case monitoring. It is designed to test the ability of a consortium of service providers to provide more accessible, appropriate, and cost-effective care.

The project has received waivers to provide certain health-related and social services which are not otherwise provided under medicare. These include: Day care services; homemaker services; chore services; home-delivered meals; interpreter services; respite care; discharge assistance; drugs and biologicals; audiology services, including hearing aids; optometry services, including eyeglasses and contact lenses; podiatry services, including orthopedic footwear and other supportive devices; dental care, including prosthodontics; adaptive and assistive equipment; transportation of patients by specialty vehicles, cabs, and other private and public means; case management services; mental health counseling; and prosthetic and orthotic appliances.

The basic assessment instrument used by the project is the patient status assessment instrument, which was used for the Public Health Service section 222 experiments on adult day health care and homemaker services. This instrument has been expanded to include items which are necessary for care planning and determination of appropriate patient placement. Material from the Monroe County, N.Y. (ACCESS) instrument was used in the revisions. The resulting instrument has been field-tested extensively, further revised, and validated.

The project developed a formal training program for project staff in assessment, care planning, and case management functions. In addition, Mount Zion has established a seminar program to provide project staff as well as consortium members and other hospital personnel an opportunity to increase knowledge regarding long term care. Knowledgeable individuals from Mount Zion Medical Center and the community are leading the seminars.

In August 1980, the project became operational. As of August 1981, the project had reached its projected caseload of 200 experimentals and 100 controls.

Evaluation.—The project research director is responsible for a detailed evaluation of project. Berkeley Planning Associates will include this project's data in its HCFA crosscutting evaluation.

San Diego, North San Diego County, Long-Term Care Project

The purpose of this demonstration is to compare client benefits and costs of care between existing long-term care services and those provided under the project. The project will provide a comprehensive, coordinated system of long-term care for medicare beneficiaries aged 65 and over. The hypothesis to be tested is that a coordinated system of long-term care service delivery for medicare beneficiaries 65 and over, providing continuity of care with a wide array of in-home, community-based, and institutional resources, stressing client education for self-care and client participation in care plan development, will result in clients achieving and maintaining optimal health status and functional independence and will assist in containing the overall costs of health care.

In designing the demonstration, the project established broad goals: (1) To demonstrate that a medicare-certified provider of home health services with a range of supplementary in-home supportive services, and an established system of community-wide linkages, is an appropriate and cost-effective resource for the administration of a long-term care system; (2) to assist the frail elderly, chronically ill, and disabled persons 65 and over to acheve and maintain an optimum level of health, self-care and functional independence in their own homes and cultural environment; (3) to assure appropriate and acceptable out-of-home placement only after a thorough exploration of personal and community resources demonstrates that needs cannot be met at home.

The project builds upon the existing scope of medicare-covered home health services provided by the Allied Home Health Association and the Visiting Nurse Association. Through this delivery model the project links an existing information and referral network with a centralized single entry system. The project services include: professional assessment of client needs, client participation in care plan formulation, and case management. The project contracts with providers for delivery of services.

The project will provide the following services under the section 222 waiver authority: Adult day health care, home-delivered meals, homemaker services, escorted transportation, and patient educational services to enable the patient to follow the physician's instruction for self-care.

Approximately 500 experimental and 250 control participants will be randomized into the project sample.

During the first developmental year a patient assessment instrument which has been used by the Allied Home Health Association since 1977 was revised for use by this project to include items of broader scope. The instrument provides four levels of information: (1) Patient assessment needs; (2) services of existing community providers; (3) services provided by the patient's informal support system; and (4) medicare-waivered services specific to the long-term care project.

The project has trained the initial assessment teams. In addition, special training has been provided for project nurses and social workers in the area of care planning and case management.

The project has obtained the commitment of local service providers and referral sources.

The project became operational in January when referrals were accepted for assessment and case planning. As of August 31, 1981, the project was experiencing difficulty in reaching the projected intake goals on schedule. The delay of the approval of waivers until April 1, 1981, has affected the project's intake and has shortened the amount of time which was originally intended for intake. However, the project still intends to attempt to bring on a full population of 750.

Berkeley Planning Associates will evaluate the project along with internal ongoing evaluation by staff and consultants for management decisions.

Oregon, FIG Waiver Continuum of Care Project for the Elderly

The Oregon Department of Human Resources was awarded a grant in September 1979, to test the provision of alternative community-based services to the elderly in a five county area in the southwestern part of the State. This demonstration was funded for the first year of a 3-year project under the authority of section 1115 of the Social Security Act. The project has also received a grant from the Administration on Aging to support administration costs and an evaluation component for the project. The HCFA project became operational in January 1980.

The two components of the project—FIG (flexible intergovernment grant) and the section 1115 waivers share the same objective: To serve the elderly more appropriately and contain medicaid costs. It was expected that each component utilized separately would impact both problems to some extent; however, it was anticipated that use of both of the components together in one of the five counties would maximize that impact on deficiencies in the current system.

The FIG component most directly addresses service delivery deficiencies due to uncoordinated, unintegrated service delivery by diverse agencies serving the elderly. It has been designed to address the problems involved with a multiple agency, multiple entry service delivery system without increasing the available fiscal resources, and without initially changing any agency's internal structure. It has the following characteristics:

(1) It depends on a local policy committee (with representatives from all of the agencies which serve the elderly) for local accountability and decisionmaking.

(2) It makes available to each agency a profile of all other agencies in the local area which serve the elderly, for information and referral services.

(3) It utilizes a common functional assessment tool to assist decisionmakers in standardizing placement choices.

(4) It utilizes a common data base which returns to each agency an internal report on its own operation, and an external report on how that agency fits into the total system.

The waiver component addresses fiscal imbalance in the service system due to Federal funding patterns which encourage maximum utilization of medicaid institutionalization. This is to be accomplished through the State guaranteeing as a condition to the waiver that no additional medicaid funds, above projected expenditures, will be spent. In fact, no medicaid funds will be available for alternative services each month until it can be shown that a reduction in projected expenditure levels has been realized, and that 90 percent of the title XX funds available for these alternatives have been encumbered.

The five sites and their respective research conditions are:

—Josephine County (FIG only).
—Jackson County (FIG and waiver).
—Coos/Curry Counties (waiver only).
—Douglas County (comparison).

Each site is conducting assessment and reassessment care planning and case management with followup by currently employed county personnel. The project is targeted to individuals 65 years or older who are eligible for medicaid and title XX benefits and have been assessed as eligible for in-home services instead of nursing home placement.

Certain health-related and social services which are not otherwise provided under title XIX are provided under waiver authority in the two waivered counties only. These include: Homemaking and housekeeping services, chore services, home-delivered meals, adult foster home services, adult residential services, and limited transportation services.

The specific objectives of FIG/waiver project are:

—To overcome fiscal imbalance and service delivery deficiencies in current title XIX program.
—To achieve cost containment.
—To provide alternative community-based service to elderly persons to delay or prevent institutional placement.
—To provide more appropriate in-home health services without increasing current fiscal resources allotted to institutional and in-home titles XIX and program components.

The basic patient assessment instrument utilized by the project is known as the placement information base (PIB), which was developed by the State prior to the current demonstration. Although shorter than most instruments currently being used in demonstration projects, the PIB contains the important items that provide information on which a decision to maintain a person in his own home can be made. The items are organized to obtain pertinent information regarding an individual's ability to communicate, to ambulate, to manage his living environment, to perform both activities of daily living and instrumental activities, and to handle financial affairs. The instrument is currently being used statewide for adult services. This instrument is used by county agency personnel, by providers (for referrals made to the project) and by project staff. A trading program has been developed for all project staff to assure uniform application of the expanded assessment instrument in the five-county area.

Results to Date by County

Josephine County (*FIG only*).—Since project implementation, nursing home expenditures and caseloads have been well below predicted levels. Community-based care expenditures and caseload have been consistently higher than the predicted levels mainly due the FIG component, in addition to increased utilization of housekeeper and personal care services, home-delivered meals, and residential care facilities. (All of which are part of the current Oregon State plan.)

Jackson County (FIG and waiver).—Since project implementation, community-based caseloads and expenditures have been considerably above predicted levels. Nursing home caseloads and expenditures have been well below predicted levels.

Coos/Curry Counties (Waiver only).—Experience in the first three-quarters of the project show that the nursing home caseload has increased substantially compared to the predicted caseload with or without project intervention. Nursing home expenditures have increased less but still more than that predicted with project intervention.

Utilization of community-based services has increased along with expenditures, well above the levels predicted without the project. Efforts to increase utilization of community-based services, and to expand the target population receiving those services, have proven ineffectual to date, and have not decreased the nursing home caseload. Utilization of waivers only, or increases in the amount of funding for community-based services without local cooperation and planning, have not resolved problems in the delivery of services.

Douglas County (comparison).—Caseloads and expenditures for the nursing home program continue as expected. Both community-based care caseloads and expenditures remain above predicted levels in this county. However, the increase in utilization of community-based servcices has had no significant impact to date on nursing home growth.

The project results to date in the FIG only and the FIG/waiver counties are similar. Both counties have shown consistent reductions in expenditures of medicaid funds for nursing home care. It appears that the FIG component continues to have significant impact on the long-term care system in both counties. Results in the waiver only and the comparison counties tend to reinforce the tentative conclusion that local agency cooperation and planning toward the goal of preventing or delaying nursing home placement are vital to impacting nursing home utilization.

The provision of additional financial resources (e.g., waivers) without other intervention (e.g., FIG component) has not significantly impacted nursing home growth in the five counties involved in the project.

The State did not request a third year of funding for this waiver-only medicaid demonstration.

The State has begun to phase down project operations and client and fiscal data tracking were terminated June 30. The final 3 months of the project will be devoted to analyses of the data base and preparation of the final project report to be submitted to HCFA in October 1981.

The State has noted that it has been very satisfied with project results and will attempt to implement the effective components of the demonstration on a statewide basis. The FIG-only component has proved to be the most effective in meeting the project's objectives. Therefore, the State legislature recently passed SB 955 creating a Senior Services Division under the State Department of Human Resources to administer a statewide program based on the FIG component of the project.

SB 955 provides local governments with a choice of continuing the present local organizational structure in which the area agency on aging manages title III and the Oregon project independence in-home care program, the State manages title XX in-home care, substitute homes and title XIX nursing home care; or the local government may elect to manage all of these programs under the local area agency on aging.

Evaluation.—The State will conduct its own evaluation report due in October 1981, and Berkeley Planning Associates will conduct an evaluation as part of the HCFA crosscutting evaluation.

South Carolina, Community Long-Term Care Project

The South Carolina Department of Social Services is conducting a 3-year demonstration to test community-based client assessment, services coordination, and provision of alternative services. The project has also received funds from the Appalachian Regional Commission to pay part of the administration costs of the project. A major goal of this project is to establish a community network of services that support the efforts of disabled and elderly individuals to remain in their communities. The network will have a self-sustaining community structure without a separate coordinating agency, thereby developing an integrated model for long-term care services. The project's catchment area covers these countries: Spartanburg, Cherokee, and Union. Each of the counties has established community advisory groups to discuss the project's activities and progress in implementing the program.

Key operational components of the project include: Community-based client assessment; reassessment; and service coordination toward provision of services which are alternatives to institutionalization. The population to be served are medicaid-eligible elderly individuals with functional disability who are at risk of nursing home placement. Two thousand individuals are expected to enroll in the project over the 3-year demonstration period (55 percent of caseload from the community; 45 percent from nursing homes). The experimental research design (with random assignment of clients to experimental and control groups) was implemented at the time the project became operational in July 1980.

The project provides waivers for health-related and social services which are not otherwise covered under medicaid. The services include personal care, medical day care, respite care, home-delivered meals, transportation, medical social services, physical, occupational and speech therapies, mental health counseling, medical equipment, eyeglasses, dentures and dental services. The project limits the cost of the waived services to no more than 75 percent of the medicaid cost for institutional care. In addition, as a measure to control medicaid service costs, the program emphasizes the utilization of existing public resources, e.g., medicaid, and title XX services and private resources prior to making a referral for the waived community services.

A standardized assessment instrument administered by county caseworkers is used for all prospective clients. The assessment instrument was based closely on the instrument developed by the Monroe County, N.Y. ACCESS project. The South Carolina instrument has undergone a number of revisions to meet the unique needs of this primarily rural population. The assessment is required as part of the title XIX nursing home application process. A service management team performs all of the case management functions. Clients are reassessed at 90 days, 180 days, and every 6 months thereafter.

The major problems encountered with implementation in the first project year focused on operational and administrative issues. The attrition rate was higher than the project anticipated. The major reasons for the attrition were persons not consenting to participate, death, persons inappropriate for the program, and ineligibility for medicaid. Difficulties in developing service providers in this initial startup phase also had an impact on service utilization. More units of service were authorized than utilized for each expanded service, partly because providers were not available or had staffing difficulties. With the expansion of services and an increased number of providers the project anticipates that these problems will be minimized.

During the first year of operational activities there were 1,669 referrals and 1,271 assessments. The project randomly assigned 556 clients to the experimental group and 600 clients to the control group. By the end of July 1981, 363 experimental clients and 358 control clients remained. Personal care was the most utilized waived service followed by medical day care, meals, and medical social services.

Assessment and operational data have been maintained by project staff. The installation of a computer terminal and printer have facilitated data analysis and the establishment of an on-line operational data system. Project staff have been working closely with the State MMIS so that claims data can be processed.

On September 30, 1981, section 222 waivers were approved to address the needs of project clients who are eligible for both title XVIII and title XIX benefits. With removal of the restrictive policies of the home health section of medicare through use of waivers, the South Carolina Department of Social Services proposes to increase the utilization of home care services and thereby reduce reliance on acute care settings. It was also anticipated that these changes would reduce the incidence of conversion to medicaid in nursing homes in the project area.

Since the South Carolina PSRO will terminate their involvement in preadmission screening and utilization control in long-term care facilities by the end of the year, the State has approved positions to implement mandatory preadmission screening statewide beginning on January 1, 1982. Because of the State's interest in the South Carolina project, it is reviewing options to phase in the service management program statewide.

Evaluation.—The evaluation of the project will include an internal evaluation of the research hypotheses by the State and a secondary review of the project by Berkeley Planning Associates. The goals of the internal evaluation are to determine the total utilization of services and costs for clients in the project and to identify the impact of waived community services on utilization and costs. Data will be collected from the assessment and reassessment instruments for client characteristics, and service utilization and cost information will be collected from the assessment teams, the State MMIS, medicare, and the title XX agency.

Florida, Ancillary Community Care Services

The Florida Department of Health and Rehabilitative Services is conducting a 3 year "waiver only" demonstration project under section 1115 of the Social Security Act, to develop and test ancillary community care services for the chronically impaired elderly.

The purpose of the project is to establish in five Florida counties (Broward, Orange, Duval, Pinellas, and Polk) a model of preventive, maintenance and restorative health care systems for medicaid eligibles, who are noninstitutionalized, functionally impaired persons aged 60 and over. The project's goals include the following: (a) To assist persons 60 years of age and older identified as "at risk" of institutionalization to remain in the community by helping them maintain a level of self-sufficiency through provision of health and related services not provided under the State's medicaid programs; (b) to conduct a study of individuals receiving ancillary community care services to determine the effectiveness of community-based sociomedical services; (c) to evaluate the organizational structures and costs related to each site, including but not limited to—client impact, staffing, annual budgets, urban/rural orientation, service cost, referral networks, and incidence of undetected health problems.

Each of the five county agencies will be responsible for the development of individual care plans, case management, and contracting for services with local providers. The demonstration project consists of three major components:

(1) A comprehensive medical—social assessment (CMA) designed to: (a) Provide a comprehensive health examination and a functional assessment; and (b) to collect information about the general health, mental health, physical impairments, availability of social resources, unmet needs, and living conditions of older persons.

(2) A case management system; and

(3) Six ancillary community care (waivered) services, including—personal care services; specialized home management services; medical therapeutic services; respite services; day treatment services; and medical transportation services.

During the first developmental year of the project, the following tasks were completed:

(1) Key staff including the project director, deputy director, and data specialist have been recruited and oriented.

(2) A protocol manual for project implementation has been developed.

(3) A training program for the five sites has been developed, with plans to use the first site to train and orient site personnel from other sites.

(4) Contractural arrangements have been established with physicians and a management firm to help with training and administrative protocol manuals.

(5) The project has initiated working relationships with the State medicaid program.

(6) The existing State MIS has been modified to track all project expenditures, and the project has arranged with Blue Cross to perform a similar service in relation to medicare services and costs.

Operational Phase

The first site, Duvall County, became fully operational in March 1981.

Sites 2 and 3, Polk and Pinellas Counties, became operational in April, and sites 4 and 5, Orange and Broward Counties, began providing services in June.

As of August 7, 1981, the sites had enrolled 360 participants.

Contracts have been negotiated for the six waivered services at each site. Reimbursement is based on a fixed price for each unit of service provided to a participant.

A protocol manual was published in May 1981, which was designed to assist the project site staff at the sites to provide service as efficiently and effectively as possible. It also insures as much standardization as possible between sites for comparative purposes.

A cost information system to account for the types of services, the number of units, and the funding sources with client identifiers has been completed and tested. A preliminary computer run will become available on October 30, 1981.

Technical assistance has been provided by the project's (State) evaluation staff to the sites to help them understand the data collection requirements.

Orange County was substituted for Dade County when a channeling contract was awarded to the Miami Jewish Home and Hospital for the Aged.

The State legislature has appropriated the matching funds necessary for the third project year.

State staff has visited each site monthly since January to assist with preoperational activities, monitor operations and provide onsite technical consultation.

Texas, "Modification of the Texas System of Care for the Elderly: Alternatives to the Institutionalized Aged"

The Texas Department of Human Resources (DHR), is conducting a 3-year "waiver-only" demonstration project under section 1115 of the Social Security Act to develop and test a comprehensive continuum of care for the aged that is appropriate in terms of quality of care, preferences of recipients, and costs.

This demonstration was initiated as a result of a State legislative mandate to eliminate unnecessary and inappropriate utilization of nursing home services. The mandate requires DHR to eliminate one of the two medicaid ICF levels of care (ICF–II and ICF–III) and to provide community-based services to patients who can be deinstitutionalized. A State appropriation was voted to carryout the intent of the legislation.

As of March 1980, the distinction between ICF–II and ICF–III was eliminated so that only a single ICF program (in conformity with Federal regulations) now exists below the SNF level. Some of the individuals who were receiving benefits in ICF–II are being deinstitutionalized to community-based settings and provided with alternative health-related services. The remaining individuals will be "grandfathered" into the single ICF program.

Under this project a 5-percent sample of the 18,000 institutionalized patients in level II ICF's will be assessed to determine their discharge potential. For those who are deinstitutionalized a care plan will be developed and arrangement for in-home services through community service providers will be made. In addition, the project will conduct case management, monitoring, and followup activities for project participants.

The following services will be provided: Medicaid home care benefits, medicaid personal care benefits, title XX adult in-home services, and section 1115 waivered community-based in-home supportive services.

The objectives of the project are:

—To create a single ICF level of care (by eliminating level II).

—To increase the availability of alternative care services in communities.

—To develop a new State assessment instrument that is appropriate for institutional discharge planning.

—To assure appropriate continuing care for current level II ICF patients.

As of March 1980, the State had terminated all new admissions to level II ICF. Standards for SNF's and ICF nursing homes have been revised and new criteria for ICF's have been established. In addition, a plan for monitoring long-term care facility admissions has been developed.

The project became operational on March 1, 1981.

Evaluation.—An ongoing project evaluation will be done by the State planning and evaluation unit located within the State Office of Management Services. It will consist of documentation of the system developed to meet and test objectives and evaluation of outcomes. In addition, Berkeley Planning Associates will include the project in their crosscutting evaluation.

Colorado: Medicaid Physician Nursing Home Visitation Project

The primary objective of this project is to determine whether the elimination of existing regulations which regiment the frequency and intervals of physician visits to nursing home residents will improve physician involvement in nursing home care, improve the quality of physician-patient interaction and thereby improve the quality of medical care.

The State Department of Social Services plans to contract with the Colorado Foundation for Medical Care for planning and implementation activities.

The foundation is the Colorado Professional Standards Review Organization. Currently, the State Department of Social Services through its Division of Medical Assistance, has a formal relationship with the foundation.

The project will be carried out in four phases—developmental, pilot, implementation, and evaluation.

During the 3-year demonstration period, the following activities will receive emphasis:

(1) Development of the research design and demonstration methodology.

(2) Development of the necessary criteria and standards for the project.

(3) Education of physicians and nursing home personnel.

(4) Assessment and monitoring of patient care planning efforts and physician performance.

(5) Analysis of research results and evaluation of the extent to which the research hypotheses were supported by the data.

Four hypotheses have been identified to prove or disapprove the primary objective that elimination of the regulations that mandate the frequency and interval of physician visits to nursing home residents will improve physician involvement in nursing home care and also improve the quality of care. The four major hypotheses are:

(1) A flexible framework of physician-patient encounters for long-term care residents, based on patient need, coupled with physician-patient care planning and supported by a prospective planning system in the facility will change the distribution of patient-physician encounters.

(2) A flexible framework of physician-patient encounters coupled with patient care planning will improve quality of patient-physician interaction.

(3) A flexible framework of physician-patient encounters by itself will change the distribution of patient-physician encounters and will not negatively affect the quality of patient care.

(4) The costs of care will continue at the current level in a system where physician-patient encounters occur based on patient need rather than regulation.

The project participants will be divided into three groups—an experimental, a semiexperimental, and a control.

The experimental group will consist of facilities in which existing regulations for physician visitation will be waived. The physician will, instead, develop a patient care plan in which he will specify the frequency of physician-patient encounters required by the patient's condition. The physician will be supported by a system of prospective patient care planning in the facility, i.e., facility staff will be trained to operate such a system.

The semiexperimental group will consist of facilities in which existing regulations for physician visitation will be waived. However, there will be no instruction to the physician or the facility with regard to patient care planning.

The control group will consist of facilities which will continue to operate under existing regulations and the existing methods and approaches for enforcing those regulations.

A total of 9 to 15 long-term care facilities will be selected to participate in this project. Hopefully, 3 to 5 facilities will be assigned to each of the three study groups.

The following data will be collected at specific time frames from each group of participating nursing homes in order to measure: (1) Physician involvement in long-term care; (2) physician-patient interaction; (3) quality of care; (4) hospital admission; and (5) costs of care.

The implementation of a monitoring/intervention system will be measured using the management information system of the PSRO.

The research design will be a pretest and posttest control group design subjected to a six-way analysis related to each of the three treatment groups prior to and during the project.

Four waivers will be granted under the authority of section 1115 of the Social Security Act to enable the State to implement the project. These are:

(1) *Statewideness, 1902(a)(1):* To permit the project to be conducted in a sample of experimental facilities in the State.

(2) *Administration of the State plan, 1902(a)(5) and medical review and periodic inspections, 1902(a)(26):* To waive current State and Federal requirement for extended stay review.

(3) *Amount, duration, and scope of services, 1902(a)(10):* To permit physicians to develop their own visitation schedule according to plans of care based on individual patient needs in intermediate care facilities and skilled nursing facilities; and

(4) *Independent medicare evaluations in skilled nursing facilities (SNF), 1902(a)(28):* To permit the State to develop the project research, demonstration, and evaluation methodology in the SNF's.

The project was approved on February 25, 1981. However, certain questions were raised to clarify the demonstration and research designs and these must be satisfactorily answered before project implementation can be undertaken.

Evaluation.—The State Department of Social Services intends to contract with the Colorado Foundation for medical care for the evaluation, once independent funding is obtained.

NATIONAL LONG-TERM CARE CHANNELING DEMONSTRATION PROGRAM

The national long-term care demonstration program supports the development and implementation of community-based projects to coordinate, manage, and arrange for the provision of appropriate and efficient long-term care services for the functionally impaired elderly. This program is an intradepartmental effort which includes the close cooperation of HCFA, the Administration on Aging (AoA), and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) which was designated as the lead agency for the effort. The program was initiated in October 1980, and it is expected to continue through September 1984. The term "channeling" refers to the organizational structures and operating system required in a community to make sure a client receives needed long-term care services. The primary elements of this concept are: Outreach/case finding; screening; comprehensive client assessment; and case management. Case management is viewed as the element of the project which provides the most important means for channeling the delivery of services to clients according to their individual needs. Case management functions include: Case planning; arranging for services; and monitoring and reassessment.

The program includes the following four components:

1. CHANNELING DEMONSTRATION

Twelve States were originally awarded contracts to conduct Channeling demonstrations. These States were: Maryland, Maine, Pennsylvania, Texas, Kentucky, Hawaii, Florida, Massachusetts, Missouri, New Jersey, New York, and Ohio. However, budget reductions incurred by HCFA and AoA have necessitated scaling back the size of the program to a maximum of 10 States. Therefore, Hawaii and Missouri will not be funded beginning in October 1982. Of the remaining 10 States, five (Maryland, Maine, Texas, Kentucky, and New Jersey) will remain basic model States; i.e., they will provide only the primary elements described above. The other five (Pennsylvania, Ohio, Florida, Massachusetts, and New York) will be complex models; i.e., they may apply for waivers to expand services and test alternative reimbursement mechanisms. Seven of the States were also awarded service expansion funds to allow them to expand service availability to channeling clients. The purpose of the additional funding is to fill gaps in the service package available to the community, including the development of new services.

The project is currently in the preoperational planning phase. The basic model programs will become operational in February 1982, and the complex model programs will become operational in April 1982.

Channeling expects to serve a total of 6,800 clients. These clients will be randomly assigned to experimental and control groups of roughly equal size.

As part of the demonstration program, the State projects are required to establish an interagency long-term care planning group to prepare a State long-term care plan. Members of the planning group are designated by the Governor of each State.

2. EVALUATION CONTRACT

A contract was awarded to Mathematics Policy Research, Inc., to conduct the evaluation. Mathematics will collect uniform data on client characteristics, outcomes, and costs. In addition, the evaluator will assist the project in utilizing procedures for randomizing the potential client population into experimental and control groups.

3. TECHNICAL ASSISTANCE CONTRACT

A technical assistance contract has been awarded to Temple University Institute of Gerontology to provide support to the demonstration projects in developing uniform assessment and data collection procedures.

4. STATE SYSTEM DEVELOPMENT GRANTS

Fifteen States received 1-year system development grants. This grant program, which is intended to help States build their capacity to plan, coordinate, and manage the allocation of long-term care resources, terminated at the end of fiscal year 1981. The system development program parallels task I of the State long-term care channeling demonstration contracts.

The system development grants were monitored by AoA. The evaluation and technical assistance contracts are jointly monitored by teams comprised of representatives from ASPE, HCFA, and AoA.

Monitoring responsibilities: Of the 12 current channeling demonstrations, 6 are being monitored by HCFA (Maryland, Maine, Pennsylvania, Kentucky, Texas, and Hawaii) and 6 are being monitored by the Administration on Aging (Florida, Massachusetts, Missouri, New Jersey, New York, and Ohio).

Pennsylvania: Long-Term Demonstration Project

State Contractor

A contract was awarded to the Pennsylvania Department of Public Welfare (DPW) to conduct a demonstration under the national long-term care demonstration program. The channeling project is located in the DPW Office of Policy, Planning and Evaluation, Bureau of Research, Evaluation and Information Systems. The Office of Policy, Planning and Evaluation is directly responsible to the Secretary of the Department to provide overall direction and coordination for the many program offices within the department.

Two additional cabinet-level departments participated in the development of the proposal and have committed their continued involvement and support toward the implementation of the project. They are: department of aging and the department of health.

Prior to submitting a proposal to the Department of Health and Human Services, the three departments formed an interdepartmental work group and developed a memorandum of understanding (MOU) which set forth the roles and responsibilities of the group in planning the project, delegated the Department of Public Welfare (DPW) to be the lead agency, and recommended that DPW have responsibility for administering the project, if approved for funding.

A long-term care planning group, including the original interdepartmental work group members, will be responsible for preparing a State long-term care plan. A working subcommittee, comprised of senior staff representatives, will assist the planning group in its tasks. In addition, provision will be made to obtain community-level, consumer and provider input into the planning process.

The Department of Public Welfare has subcontracted with the Philadelphia Corp. for Aging (PCA), a nonprofit corporation, which is the designated area agency on aging for the city of Philadelphia to conduct the channeling demonstration. Philadelphia is the catchment area.

Channeling Project Organization

The local project under the direction of the project director is an administratively distinct unit under the Philadelphia Corp. for Aging's Office of the assistant director for operations. The project director will be assisted by a staff which includes—a service management supervisor, two caseworker supervisors, a nurse practitioner, two intake workers, and 12 caseworkers.

Channeling Functions

Outreach/Case Finding.—The project will engage in a series of efforts to educate agencies about the project and to develop relationships with potential referral sources. Referral protocols will be developed along with public information materials.

Screening

The screening function will be carried out initially by two intake screening workers under the direct supervision of the project director. As caseloads begin to approach capacity, however, one of the intake and screening workers will be moved to a caseworker position and the screening process will be continued by a single worker.

Assessment

Assessments will be administered by bachelor degree-level or master's degree-level caseworkers. These caseworkers will be employed by the PCA and will be supervised by two masters degree-level caseworker supervisors. All assessments will be reviewed by a casework supervisor and the nurse practitioner. When further health care assessment is required, the nurse practitioner may visit the client with the caseworker or recommend an appropriate resource for specialized assessment. Consultant assessment will be arranged through the service management supervisor.

Case Management

Case Management will be carried out by 12 caseworkers who will be responsible for the face-to-face client assessment. Actual development of a proposed care plan will take place following the assessment and following contacts with all client collaterals, previous service providers, if any, and/or others who might offer useful information for care planning (assuming client consent is obtained for the above).

The care plan will be reviewed by the worker's supervisor and the nurse practitioner prior to the worker's discussing the care plan with the client, obtaining client consent, and initiating service arrangements.

The caseworker will be responsible for monitoring the execution of the care plan with service providers, the client, and family members or informal resource networks. A process for service provider feedback to the case worker following the initiation of service will be developed.

Monitoring and Reassessment

Caseworkers will monitor the progress of clients in their caseload, contacting the client at least once each month. Six months' reassessments will be carried out by caseworkers and will undergo a similar review process as the intitial assessments. There will be occasions, however, for conducting a full reassessment ahead of the 6-month period.

Services Audit and Program Review

The service audit and program review function will be carried out by the Philadelphia Health Management Corp.

Client Caseload

The project expects to serve a caseload of between 720 and 780 clients for which the ratio of clients per worker is expected to range between 60:1 and 65:1.

Evaluation

The project will be evaluated by Mathematica Policy Research, Inc.

Texas: Long-Term Care Demonstration Project

State Contractor

Through the passage of legislation in 1979, the State has promoted new alternate care services and made a fiscal commitment to community-based programs. In response to this legislative commitment, the Texas Department of Human Resources and the Governor's Committee on Aging and other State agencies working in the long-term care network are increasing their interaction and their efforts to bring about recommended changes in the delivery system. The Texas Long-Term Care Channeling Demonstration Project awarded to the Texas Department of Human Resources in 1980 represents an important step by the State toward making effective changes in the long-term care delivery system.

Long-Term Care Planning Group

The State long-term care planning group is an active and committed body which is composed of agency commissioners or lead executives, a representative from the Governor's office and State Legislature and citizens knowledgeable in the field of long-term care. The planning group has established smaller working groups with staff assistance and technical guidance from the State contractor and a working group representing State agencies involved in long-term care. Data collection and analysis for the plan have been completed and the first draft of the plan has been presented for review by the relevant State agencies. The planning group is holding nine public forums across the State in October and Novmber to review and comment on the proposed plan.

Demonstration Site

Houston was selected as the site in Texas to demonstrate channeling. The administering agency is the Texas Research Institute of Mental Sciences Gerontology Center (TRIMS). TRIMS is a research, training, and service facility of the Texas Department of Mental Health and Mental Retardation. TRIMS is located in the Texas Medical Center. The channeling project's catchment area includes the Houston central business district and communities to the west, north, and south of the business district. The area includes the incorporated community of Jacinto City. Drawing from this catchment area, TRIMS expects to have a caseload of 400 by the end of the first year.

Project Organization

The Texas channeling site staff consists of 15 staff members. While the site will directly employ 13 staff members, subcontracts will be developed to hire an experienced case manager from Sheltering Arms, a United Way agency, and a case manager from the Houston Department of Human Resources Regional Office. The case managers hired under subcontract will be located with the staff at the channeling site.

Since implementation of the project will depend upon interagency collaboration, TRIMS has established a channeling advisory council composed of community providers. This council has established four committees to facilitate site development: (1) Outreach/case finding; (2) screening; (3) case management; and (4) informal support systems. Once the site becomes operational in February 1982, it expects to establish a channeling operations group composed of representatives from the provider agencies serving 50 or more project clients to review care plans and complex cases.

Channeling Functions

Outreach/Case Finding.—The project will seek to conduct case finding and outreach activities to identify a broad spectrum of potential clients, reflecting the diverse population of the catchment area. Referral agreements with community agencies will establish multiple access points for identification of potential clients. In addition, the project will establish linkages with police, medical practitioners, hospitals, voluntary, religious, and business organizations. The site has proposed a full-time community outreach and development specialist who will be involved in the informal community network both to identify clients and to mobilize volunteer and informal resources.

Screening

Because of the importance of the screening function to the client and overall project, two staff members will devote full-time effort to intake and screening activities. These individuals will be located at TRIMS which will serve as the screening and entry point. The intake and screening specialist will receive incoming referrals of potential clients: gather and record background information on each client using the screening instrument; and refer the clients appropriately to the project or to other community agencies. These screeners will be supervised by the site director.

Assessment

The assessment will be completed by one case manager or a supervisor on the channeling staff. However, in a small percentage of cases, two channeling staff members will be involved in the assessment of a particular case. Situations that might warrant this include cases where a married couple is involved, where the client's environment is potentially unsafe, or where specialized consultations are necessary. Clients will be assigned to case managers based on the client's geographical residence and the need to assign a bilingual case manager.

Using the prescribed assessment instrument, each case manager will conduct at least one home visit or in-person visit to complete the initial assessment. They will also utilize telephone and face-to-face contacts to obtain more detailed information needed to complete the assessment. Signed releases of information will be utilized to obtain any appropriate written records from sources of medical and/or psychiatric treatment. During supervisory conferences, each case manager will review new assessments with his/her supervisor who is responsible for assuring the assessment procedures are adhered to with uniformity.

Case Management

The six case managers will function in two teams (one nurse and two social caseworkers on each team) for purposes of case conferences and team supervision. Once a client is assigned to a case manager for assessment, the case manager will follow through on the case management functions for the client. This approach assures continuity in planning and coordinating client care and service needs. For care planning, the project expects to conduct case conferences and build on the expertise of the assessments by the medical and legal consultants. In addition, interagency staff representing major providers will have the responsibility for review of complex cases and participation in care planning.

Monitoring and Reassessment

Monitoring of service delivery and changing circumstances of clients will be carried out by the responsible case manager. Some cases will require more intensive followup particularly as services are first initiated or are being changed for any particular reasons. It is anticipated clients with no functioning informal support system will need more routine followup. Reassessment will be done routinely on all project clients at least every 6 months. The timing of individual reassessments will be based on the individual's functional status or significant change in the environment.

Client Caseload

The project expects to serve a caseload of about 400 clients for which the ratio of clients per worker is expected to average 67 : 1.

Evaluation

The project will be evaluated by Mathematica Policy Research, Inc.

Hawaii: Long-Term Care Demonstration Project

State Contractor

The Governor of the State of Hawaii designated the State Department of Social Services and Housing as the lead agency for the national long-term care demonstration project. Within the department, the public welfare division has leadership responsibility for the project. The public welfare division provides two major types of services: (1) Income maintenance, and economic and medical assistance (among the programs covered under this division are title XIX and food stamps) ; and 2) social services programs which include title XX and State-funded service programs.

At the State level, the staff includes a project administrator and planner in addition to support by the assistant public welfare administrator. The State staff will provide assistance to the State long-term care planning group.

Long-Term Care Planning Group

The State has established a planning group composed of key officials from the State agencies concerned with long-term care, a representative from the Governor's office and budget offices. In preparation for a preliminary draft plan, the State contractor has collected data regarding services and the demographic composition of the elderly Hawaiian population. This plan has undergone substantial review and comment by the planning group, State and local government and community providers. The final draft is currently under review.

Demonstration Site

The Oahu branch, Department of Social Services and Housing located in Honolulu, has the responsibility for administering and implementing the community-based project. The State has titled the project, Project Malama. Malama is a Hawaiian word meaning to care for, to keep, to preserve, and to observe. The Oahu branch has units in the catchment area which processes applications for money payments, food stamps, and medicaid, and provides services to recipients.

Since Hawaii will have the opportunity to complete phase I activities but will not receive additional Federal support for phase II, the State is reviewing the organization, structure and operations for the channeling project. At a minimum the State must meet the requirements of the tasks delineated in the RFP. The site is not required to meet the research and evaluation requirements. Therefore, the State staff and site director is in the process of preparing an implementation plan which fulfills the RFP requirements and specifically relates to the long-term care needs of the Hawaii elderly population.

Evaluation

The project will be evaluated by Mathematica Policy Research, Inc.

Maine: Long-Term Care Demonstration Project

State Contractor

The Maine Department of Human Services was awarded the contract for the national long-term care channeling demonstration. This department is the State's major umbrella agency for health and social service programs with responsibility for administering the titles XXX and XX programs of the Social Security Act, and title III of the Older Americans Act.

The Bureau of Maine's Elderly, the State agency on aging was designated by the Department of Human Resources as the lead agency for planning and implementation at the State level. The director of the Bureau of Maine's Elderly has the overall responsibility for contract management. The State-level project staff consists of a program manager, project officer, and research associate.

Long-Term Care Planning Group

The State has established two distinct, although related, planning groups. The state long-term care planning group consists of bureau directors from the Department of Human Services and the Department of Mental Heatlh and Corrections. The composition of the group is consistent with the planning and decisionmaking structure of the department and represents a concerted effort to integrate long-range planning for long-term care services into the main stream of current activities. A second group, which is coordinated with the first, is focusing on the operational aspects of the long-term care channeling contract. This group is chaired by the director of the Bureau of Maine's Elderly. Members of this group will also include bureau directors, representatives of community agencies, and other units of State government.

The project officer and research associate provide staff support to the planning group. Currently, a draft plan is being reviewed by the planning groups. The project anticipates holding public forums on the completed long-term care plan in two areas of the State in December.

Demonstration Site

The local community demonstration site will be administered under a subcontract with Southern Maine Senior Citizens, Inc., an area agency on aging in Portland. This agency is a voluntary, nonprofit agency administered by a citizen board of directors. The catchment area for the project covers Cumberland and York Counties which represents an urban, suburban, and rural mix. The caseload is expected to be approximately 300 clients.

Project Organization

The director and planner of Southern Maine Senior Citizens, Inc., will provide information and support to the site. The site, however, will be directed by a project site director, who will be accountable to the project officer in the Bureau of Maine's Elderly. The site director will be responsible for community education, general public relations, the establishment and monitoring of service linkages with providers and the supervision of the community services coordinator and screeners. The coordinator's responsibilities include participating in the development and implementation of policies and procedures for coordinating service delivery, and supervising individual service coordinators. The six individual service coordinators will represent an interdisciplinary team with backgrounds in nursing, social work, and physical or occupational therapy.

Site-level activities will also receive input from a community-based advisory committee, elderly-at-risk, which represents more than 30 provider and planning agencies, as well as older persons from the region. This committee has already been established and meets on a regular basis to provide community input into the development and operation of the project. The site director provides staff assistance to the committee.

Channeling Functions

Outreach/Case Finding.—The project has identified several community agencies, hospitals, nursing homes, housing authorities, senior citizen centers, and churches as potential sources of referrals. These community agencies will be encouraged to refer potentially eligible clients to the project. In addition, to insure that the population with French as a first language has familiarity with the project, bilingual flyers will be distributed through the referral network and into community social clubs to reach potential clients and their families.

Screening

The project proposes to hire two part-time screeners working a total of 40 hours a week. The screeners will be located at the channeling site but they will be physically and administratively separate from the case managers. The site director will monitor and supervise the screeners. For those clients appropriate for the project the screener will make the referral to the site; inappropriate potential clients will be referred to the existing community network of service providers.

Assessment

The community service coordinator will assign clients to individual service coordinators for assessment, care planning, and all other aspects of case management. The individual service coordinators will use the standardized assessment instrument to assess channeling clients. Additional specialized assessments by professionals who are not a part of the interdisciplinary team may be conducted in preparation for care planning. The assignment of cases to case managers will be based on geographical residence and bilingual needs of clients.

Case Management

Case conferences will be held by the community service coordinators and individual service coordinators to discuss and review the client's assessment, service needs and frequency and duration of service provision. The project expects to work with providers in preparation of the care plan. Goals will be developed and the prescribed services identified. The frequency and duration of these services will be discussed and agreed upon and the expected participation of family members will be clearly delineated.

Monitoring and Reassessment

The individual service coordinators will maintain periodic contacts with clients and with involved provider agencies. The agencies will reevaluate and renegotiate services depending upon the goal achievement and changing client functional needs and home environment. Formal reassessments will be conducted by individual service coordinators every 6 months. The need for additional individual reassessments will be based on the client's functional status or significant change in the environment.

Client Caseload

The project expects to serve a caseload of about 300 clients. The project expects the client per case manager ratio to be about 50:1.

Evaluation

The project will be evaluated by Mathematica Policy Research, Inc.

Kentucky: Long-Term Care Demonstration Project

The Kentucky Department for Human Resources has been awarded a contract to conduct a demonstration under the national long-term care demonstration program. This department, an umbrella agency responsible for all human services throughout the State, is mandated by Kentucky revised statutes to develop, implement, regulate, and administer Kentucky's long-term care program. In this regard, the Department delegates long-term care functions to its various bureaus and offices.

The channeling project has a strong commitment from the secretary for human resources for full financial and administrative support. The State project director also serves as the director of planning within the office of the secretary of the Department for Human Resources and therefore, reports directly to the secretary. The channeling agency is a special unit of State government made up of staff directly employed by the bureau for social services, bureau for social insurance, and bureau for health services. For the purposes of the demonstration, this unit and its personnel will be directly responsible to the State project director.

The channeling unit, with staff representatives from the three bureaus, will pool the combined resources and experiences of the State service agencies. The bureaus for social services and health services have statutory responsibilities for providing social services and health services to the State's citizens. A registered nurse will provide needed expertise for comprehensive patient assessments. The bureau for social insurance will provide an eligibility worker who will insure the technical expertise necessary for eligibility determinations. A further indication of State commitment is that the bureau for social services is committed to match the $250,000 in services expansion funds which the local site will receive under the demonstration.

Eastern Kentucky, consisting of eight counties, is the location of the local demonstration site. These counties are: Jackson, Laurel, Clay, Harlan, Leslie, Perry, Knot, and Letcher Counties.

Long-Term Care Planning Group

The State long-term care planning group, which consists of 20 members, is made up of key State policymakers and is chaired by the secretary of the department for human resources. Several subcommittees have been established to work with project and department staff in the preparation of reports for the planning group. The reports are designed to be the building blocks of the State plan. The planning group is expected to continue as an advisory group to the secretary for human resources and as long-term care advocates beyond the completion of the State long-term care plan.

Local Project

The local project, located in eastern Kentucky, is administered by a site director who will be directly accountable for the performance of all channeling functions and will be responsible to the State project director. The site director, assistant director, and core channeling team are centrally located for the convenience of the eight counties.

A long-term care advisory council will be established to assist the local site. This council will consist of service providers, provider agency board members, service recipients, and related sources which are representative of the geographical areas served. The chairperson of the council will serve on the State LTC planning group in order to provide an appropriate link of communication with the State planning effort.

Channeling Functions

Screening.—The project is planning to subcontract the demonstration's screening component to the two area agencies on aging in the catchment area. There would be one B.S. level screener placed in each location. Subcontracting the screening function to the AAA's will give channeling high visibility in the catchment area. It will also involve the AAA's more closely in the channeling demonstration.

Screeners will be employed 1 month prior to the beginning of caseload development. In addition to educating providers in their assigned four county areas, workers will be responsible for designing and carrying out a media campaign concerning the screening component of the demonstration.

Assessment

The channeling unit will consist of two components: A core team, including a registered nurse and an eligibility worker (from the bureau for social insurance); and eight county-based caseworkers (one in each county).

Upon receipt of the intake screening document, the caseworker will contact the client to schedule a face-to-face meeting to discuss the purpose of the project. If the client agrees to participate, a consent form will be signed by the client allowing the caseworker to obtain and share specific information with service provider agencies. The caseworker will complete the standard assessment instrument and any add-on assessment information which is approved by the Department of Health and Human Services (HHS). The caseworker will interview family members or service provider agencies if appropriate.

Upon completion of the assessment, the instrument will be transmitted to the core channeling unit via telecopier. The nurse will review the client assessment for health needs and participate with the caseworker in care planning to assure that health and social needs are considered. The eligibility worker will review and assist the assessment effort by determining if the individual is in need of and eligible for public benefit programs.

The assistant director will be responsible for the supervision of the assessment function.

Case Management Function

The case management function will be the responsibility of the county caseworker. However, the core team will provide direct assistance and, in some instances, will be the key broker for specific service needs.

The caseworker, in concert with the client or responsible person, will review the service plan. An agreement, signed by the caseworker and the client, will be negotiated. Based upon that agreement, the case manager will implement the service plan.

A system of county case conferences will be scheduled when multiple services needs are identified. These conferences will assist the case manager in implementing the plan. Multiagency case conferences and individual agency conferences will be utilized throughout the case management function.

County caseworkers who will complete the assessment and provide the case management function will be bachelor degree or masters degree social workers with community-based experience. Both the channeling assessment and case management functions will be decentralized. Case managers will be located in each county bureau for social services office in order to be accessible to the target population. To facilitate communications, telecopiers will be used to transmit information to and from caseworkers and the central location.

Reassessment and Monitoring

The monitoring function as it relates to monitoring the status of the client and the effectiveness of the care plan will be addressed in detail in a manual of operation. Reassessments will be completed at least every 6 months by the caseworker in conjunction with the core channeling team. Criteria will be developed to determine when a client needs to be reassessed prior to the 6-month mandatory interval.

Service Audit and Program Review

The Kentucky peer review organization (KPRO) will conduct the external service audit and program review.

Project implementation subgroup, composed of representatives from the State's division for field services, will develop a manual of operation which will provide direct assistance to the State and the site director in developing policies and procedures for project implementation.

Caseload

The Kentucky Department for Human Resources expects that a caseload of 600 clients will be served through this demonstration project and that the ratio of case manager to client will be 75:1.

Evaluation

The project will be evaluated by Mathematica Policy Research, Inc.

Maryland: Long-Term Care Demonstration Project

State Contractor

A contract was awarded to the Maryland Office on Aging to conduct a demonstration under the national long-term care demonstration program. A five-member State long-term care planning group has been established to serve as the major policymaking group for Maryland's channeling project. In this regard, the planning group, which meets on a monthly basis, will develop the State long-term care plan.

The planning group, chaired by the director of the office on aging, consists of high level State policy makers from the Departments of health and mental hygiene; human resources; budget and fiscal planning; and the Governor's office.

A project manager, planner, and community liaison comprise the staff at the State level. In addition, a State advisory group has been proposed which would be composed of representatives from both private and public agencies throughout the State as well as consumers.

The office on aging is subcontracting with the Baltimore City Commission on Aging and Retirement Education (C.A.R.E) to implement the demonstration at the local level. C.A.R.E., an umbrella agency, has given the responsibility of administering the project to the Baltimore Area Agency on Aging (AAA), which is the planning and coordinating arm of C.A.R.E. The selected site location is the city of Baltimore.

Channeling Project Organization

The channeling project director and the assistant director will share administrative functions in this manner:

- —The director will be responsible for overall supervision of the project, and will directly supervise the screening personnel, clerical staff, and assistant director.
- —The assistant director, who can also function as an assessor, will be administratively responsible for the assessment and case management functions of the project, will supervise the other three assessors, and will act as supervisor for the three senior case managers at the three subcontracting agencies.

The channeling project director will report directly to the area agency director.

Channeling unit staff will include—four screeners, two nurses, and two social workers. The case management functions will be decentralized to be provided by three agencies under contract with the area agency.

An existing advisory committee will be expanded to become the channeling agency advisory body. The advisory body will be composed of agency directors, provider staff, community leaders, and consumers.

Channeling Functions

Outreach/Case Finding.—The project wi'l launch an intensive effort to inform the Baltimore community about the channeling project in order to receive appropriate referrals. Such efforts will include meeting with individual interest groups, making use of the media, and keeping the local decision makers informed of the project's progress.

Screening

Screening will be conducted by two intake workers who will work directly for the channeling demonstration and be supervised by the site director.

Assessment

The assessment will be administered by either a nurse or social worker in the home of the client. Upon completion of the assessment instrument, it will be reviewed by the opposite member of the nurse/social worker team. If additional consultant expertise is needed, it will be obtained. The assessor will also be responsible for developing the care plan and obtaining the client's signature of consent.

Case Management

After the assessment is completed, those individuals accepted for channeling services will be assigned to one of eight case managers. The decentralized case management functions will be provided by one of three agencies—the Baltimore City Department of Social Services (local department of the State agency responsible for title XX funds), Visiting Nurse Association (VNA), and the Baltimore Jewish Family and Children's Society. These agencies are well established professional agencies of both social/health and public/private persuasions.

Case managers will be hired and housed by these three agencies although administrative accountability of case management staff will be to the channeling director and advisory body. Channeling case managers will also be physically separate from the other case managers of the subcontracting agencies. Case managers will be either nurses or social workers and they will serve only channeling clients with no other client workload.

Monitoring and Reassessment

Case managers are expected to continually monitor the services and client response. Reassessments will be conducted at least every 6 months. Criteria for conducting reassessments prior to the 6-month required interval include:

—Client's needs are multiple, but one or more may be of short duration.
—Client is identified as being in a state of deterioration.
—Provider agency recommends reassessment, and possible revision of care plan.
—Client's services are altered due to change in situation.

Services Audit and Program Review

The University of Maryland's department of epidemiology and preventive medicine will conduct an external service audit and program review.

Client Caseload

It is expected that an active caseload of 400 clients will be served through this project. The ratio of clients per case manager will be 50:1

Evaluation

The project will be evaluated by Mathematica Policy Research, Inc.

MEDICARE/MEDICAID HOSPICE DEMONSTRATION

BACKGROUND

The growth of hospice care in the United States is a relatively recent phenomenon aimed at helping terminally ill patients live with maximum comfort and minimal disruption to routine activity. Hospices emphasize palliative care for the control of pain and other symptoms of terminal illness. In addition, the hospice concept views the patient and family as a single unit of care. Many patients are able to remain at home with their families while continuing to receive hospice services. Hospices employ a broad spectrum of professional and voluntary care givers who use a multidisciplinary approach to deliver social, psychological, medical, and spiritual services.

The medicare and medicaid programs do not currently recognize hospice as a separate provider category. Under present law, the extent of title XVIII and title XIX coverage is based on the level of care a beneficiary needs rather than on a particular diagnosis or prognosis. This means medicare or medicaid will pay the lower of reasonable cost or charges for services provided to terminally ill beneficiaries who require inpatient acute care, skilled nursing facility care, or home health services for the treatment of their conditions. Therefore, some hospice organizations are participating in these programs within the existing provider classifications. Some hospice services, such as drugs used in the home and bereavement visits to the patient's family, are not reimbursable under medicare. State medicaid programs have differing coverage of hospital, nursing home, and home health services, and many States do not cover certain services integral to hospice care.

PROJECT DESCRIPTION

On October 1, 1980, HCFA implemented a 2-year demonstration project to gather data on the cost, use, and quality of care provided by hospice organizations. This project was developed to help define the scope of Federal involvement in the growing hospice movement. The 26 hospices selected to participate in this study have been granted waivers of the medicare/medicaid regulations which currently limit reimbursement for hospice services.

Waiver of these statutory requirements has permitted an expanded coverage of hospice services for beneficiaries and recipients who have agreed to take part in the demonstration. In addition to the project's 24-month experimental phase, there will be a 6-month wind-down period to allow the continuation of the special hospice coverage for those patients who become participants at the end of the active enrollment segment of the demonstration.

In order to be eligible to take part in the program, a patient must have: (1) A life expectancy of 6 months or less, (2) a primary care giver, such as a relative, friend, or paid attendant who is available to provide simple personal care and emotional support on an around-the-clock basis, and (3) entitlement to hospital insurance benefits (medicare part A) and supplementary medical insurance benefits (medicare part B) and/or eligibility under medicaid.

The decision to choose 26 organizations was based on the need for evaluation data which would reflect urban and rural differences, and variations in hospice provider types (12 are hospital-based, 10 are home health agency-based, and 4 are freestanding). Each grantee is either a certified home health agency (HHA) or has a contractual agreement with a certified HHA to provide home health services. There is at least one demonstration site in each of the 10 Department of Health and Human Service regions. For 24 of these hospices, medicaid State agencies have also agred to participate in the project and reimburse for services to medicaid recipients.

Participating hospices have been reimbursed under the demonstration for a number of items and services not currently covered by medicare and medicaid. Eaxmples include—outpatient prescription drugs (currently covered by medicaid), institutional respite and home respite services (primary care giver relief), visits by dieticians, and homemakers, supportive and counseling visits to hospice patients during occasional hospital stays, continuous care (by nurses, home health aides, or homemakers) on a shift basis in the home, certain self-help devices, inpatient hospice care, and bereavement services to family members.

The project evaluation is being jointly supported by HCFA, the Robert Wood Johnson Foundation, and the John A. Hartford Foundation. HCFA has contracted with Brown University to conduct an independent study of the project in terms of cost, use, and quality of care provided to hospice patients and their families. To more clearly understand the effects of hospice care and of reimbursement for hospice care, HCFA and Brown University will also gather information on other groups of terminally ill patients, including a selected comparison group of patients served by hospices outside the demonstration and another selected comparison group of patients served by hospitals and cancer centers which provide conventional medical care.

The evaluation will focus on: (1) Identification of the types of hospice services provided to terminally ill medicare and medicaid beneficiaries and a determination of the cost of providing these services; (2) identification of the types of services provided to terminally ill patients by conventional modes of care and a determination of the cost of providing those services; (3) comparison and analysis of the cost of services provided in-home and in inpatient settings by the demonstration hospices and conventional modes; and (4) assessment of the adequacy of the care received. The patient data collection phase of the evaluation began August 3, 1981.

The Office of Direct Reimbursement (ODR), Bureau of Support Services, HCFA, will serve as the fiscal intermediary to process all medicare claims submitted by participating hospices. Medicaid hospice claims from the participating States will either be processed by their own fiscal intermediaries or by ODR. For demonstration services provided to medicare beneficiarcies, ODR will reimburse the hospices on the basis of reasonable cost subject to retrospective cost reimbursement.

HOSPICE DEMONSTRATION SITES

Representative		District
Toby Roth (R)	BELLIN MEMORIAL HOSPITAL - Green Bay, Wisconsin	8
Bruce F. Vento (D)	BETHESDA LUTHERAN MEDICAL CENTER - St. Paul, Minnesota	4
Timothy E. Wirth (D)	BOULDER COUNTY HOSPICE, INC. - Boulder, Colorado	2
Jonathan B. Bingham (D)	CABRINI HOSPICE - New York, New York	22
Mike Lowry (D)	COMMUNITY HOME HEALTH CARE - Seattle, Washington	7
Lawrence J. DeNardis (R)	CONNECTICUT HOSPICE, INC. - Branford, Connecticut	3
Frank Horton (R)	GENESEE REGION HOME CARE ASSOCIATION - Rochester, New York	34
C. W. Bill Young (R)	HOSPICE CARE, INC. - Seminole, Florida	6
John Burton (D)	HOSPICE OF MARIN - San Rafael, California	5
William Lehman (D)	HOSPICE, INC. - Miami, Florida	13
Frank R. Wolf (D)	HOSPICE OF NORTHERN VIRGINIA, INC. - Arlington, Virginia	10
Barney Frank (D)	HOSPICE OF THE GOOD SHEPHERD, INC. - Waban, Massachusetts	4
Manuel Lujan, Jr. (R)	HOSPITAL HOME HEALTH CARE - Albuquerque, New Mexico	1
Robert K. Dornan (R)	HOSPITAL HOME HEALTH CARE AGENCY OF CALIFORNIA - Torrance, California	27
William Clay (D)	LUTHERAN MEDICAL CENTER - St. Louis, Missouri	1
Thomas J. Bliley, Jr. (R)	MEDICAL COLLEGE OF VIRGINIA - Richmond, Virginia	3
Matthew J. Rinaldo (R)	OVERLOOK HOSPITAL - Summit, New Jersey	12

Ron Wyden (D)	PROVIDENCE MEDICAL CENTER - Portland, Oregon	3
F. James Sensenbrenner, Jr. (R)	ROGERS MEMORIAL HOSPITAL, INC. - Oconomowoc, Wisconsin	9
Bill Lowery (R)	SAN DIEGO COUNTY HOSPICE CORPORATION - San Diego, California	41
Glenn M. Anderson (D)	SAN PEDRO PENINSULA HOSPITAL - San Pedro, California	32
Robert J. Lagomarsino (R)	SANTA BARBARA VISITING NURSE ASSOCIATION - Santa Barbara, California	19
Henry B. Gonzalez (D)	ST. BENEDICT HOSPITAL AND NURSING HOME - San Antonio, Texas	20
Joseph D. Early (D)	UNIVERSITY OF MASSACHUSETTS MEDICAL CENTER, PALLIATIVE CARE SERVICE, INC. - Worcester, Massachusetts	3
James M. Collins (R)	THE VISITING NURSE ASSOCIATION OF DALLAS - Dallas, Texas	3
James M. Jeffords (R)	VISITING NURSE ASSOCIATION, INC. - Burlington, Vermont	at large

Medicaid State Agencies - Hospice Demonstration

	Representative	C.D.#:	Senators:
1. California	Robert T. Matsui (D)	3	Alan Cranston (D) S.I. Hayakawa (R)
2. Colorado	Patricia Schroeder (D)	1	Gary Hart (D) William L. Armstrong (R
3. Connecticut	William R. Cotter (D)	1	Christopher J. Dodd (D) Lowell Weicker, Jr. (R)
4. Florida	Don Fuqua (D)	2	Lawton Chiles (D) Paula Hawkins (R)
5. Massachusetts	John Joseph Moakley (D)	9	Edward M. Kennedy (D) Paul E. Tsongas (D)
6. Minnesota	Bruce F. Vento (D)	4	David F. Durenberger (R Rudy Boschwitz (R)
7. New Jersey	Christopher H. Smith (R)	4	Harrison A. Williams, Bill Bradley (D)
8. New Mexico	Manuel Lujan, Jr. (R)	1	Pete V. Domenici (R) Harrison H. Schmitt (R
9. New York	Samuel S. Stratton (D)	28	Alphonse M. D'Amato (R Daniel P. Moynihan (D)
10. Texas	J. J. Pickle (D)	10	John G. Tower (R) Lloyd M. Bentsen (D)
11. Vermont	James M. Jeffords (R)	at large	Patrick J. Leahy (D) Robert T. Stafford (R)
12. Virginia	Thomas J. Bliley, Jr. (R)	3	Harry F. Byrd, Jr. (I) John W. Warner (R)
13. Washington	Don Bonker (D)	3	Henry M. Jackson (D) Slade Gorton (R)
14. Wisconsin	Robert W. Kastenmeier (D)	2	William Proxmire (D) Robert W. Kasten, Jr.

Two States have hospice projects without State Medicaid agency participation:

Missouri	William Clay (D)	1	Thomas F. Eagleton (D) John C. Danforth (R)
Oregon	Ron Wyden (D)	3	Bob Packwood (R) Mark O. Hatfield (R)

HUD/HHS DEMONSTRATION PROGRAM FOR DEINSTITUTIONALIZATION OF THE CHRONICALLY MENTALLY ILL

The Department of Housing and Urban Development (HUD) and HHS are jointly funding this demonstration to do the following: (1) Integrate the chronically mentally ill into the community and improve the quality of their lives by providing housing linked to supportive and rehabilitative services; (2) provide an environment that protects the privacy and personal dignity of the chronically mentally ill and at the same time offers incentives and encourages them to assume increasing responsibility and control over their own lives; and (3) encourage and assist States in providing housing and comprehensive health/social services for the chronically mentally ill.

For this demonstration, the chronically mentally ill are defined as "any adult, age 18 or older, with a severe and persistent mental or emotional disorder that seriously limits his or her functional capacities relative to primary aspects of daily living such as personal relations, living arrangements work, recreation, etc., and whose disability could be improved by more suitable housing conditions." (Alcoholism and drug abuse are not included in this definition.)

The following three categories of individuals may be served: Chronically mentally ill individuals currently residing in institutions but capable of more independent living; chronically mentally ill individuals at risk of being reinstitutionalized; and chronically mentally ill individuals with no prior institutionalization who are at risk, but for whom housing linked to services would provide an alternative to institutionalization.

Under this demonstration, provision of the following services is required: Case management and program planning, house and milieu management, life skill development, medical and physical health care, and crisis stabilization.

Additional services that are recommended but not required are: Vocational development, education development, family relations planning, recreational/avocational activity planning, psychotherapy, and advocacy/legal assistance.

Under the authority of section 202 of the Housing Act of 1959, as amended by Public Law 86–372, HUD is providing 40-year direct Federal loans to assist private, nonprofit corporations in the development of new or substantially rehabilitated housing. Over a 3-year period, HUD has set aside approximately $69 million in loan reservations for 229 sites in 39 States, including the District of Columbia and Puerto Rico. These sites will house from 3,500 to 4,000 residents. In addition, HUD will provide section 8 rental assistance for all of the units.

This community-based residential housing (group homes and independent living complexes) will allow chronically mentally ill persons to live more independently in the community. A group home is defined as a small living arrangement for not more than 12 persons with a homelike environment for those who require a planned program of continual supportive services and/or supervision but do not require continual nursing, medical, or psychiatric care. An independent living complex is defined as an arrangement of 6 to 10 individual apartment units that are supervised by professional or paraprofessional staff living in a separate or adjacent apartment or living off the grounds of the facility. The complex may house no more than 20 individuals with a maximum of two persons per bedroom.

Through a cooperative arrangement with HUD, HHS (HCFA, NIMH, and ASPE) will assure that the residents of the demonstration will receive an appropriate service package and reimbursement for selected services. A steering committee comprised of staff from each agency provides review and input in each phase of the program. ASPE has had the HHS coordination role, NIMH provides the guidance, direction, and review of the service component, and HCFA is committed to the approval of section 1115 waivers to provide medicated reimbursement for services that the States are unable to pay for under current funding programs. This reimbursement mechanism is considered to be transitional in that it allows a State time to secure funding for these services and thus fulfill its commitment to HUD. Each site within a State is to be covered by waivers to be approved for 3 years.

Up to 26 States are expected to submit section 1115 waiver-only grant applications to HCFA. In addition to waiving specific sections of the statutory requirements for the medicaid State plan, the grants will authorize Federal matching funds for such services as case management, supervision, training in life skills, and transportation.

To date, five States (Minnesota, Georgia, Tennessee, Vermont, and the District of Columbia) have received approval of their section 1115 waiver-only grant applications. Five more States (Oregon, New Jersey, New Hampshire, Rhode Island, and Arkansas) have submitted applications and will receive formal approval when they have sites that are ready to begin providing services. Currently, there are 24 sites (with 192 residents) in operation, 9 in the States with section 1115 waivers and 15 in other States.

HHS, with ASPE in the lead role, is currently conducting an evaluability assessment to clarify policy, management, and evaluation issues and to provide the optimal approach to the continuation and evaluation of the demonstration.

WAIVER OF PRIOR HOSPITALIZATION REQUIREMENTS FOR MEDICARE SNF COVERAGE

HCFA provided medicare waivers and contracted with Blue Cross of Oregon and Blue Cross of Massachusetts in 1977 to conduct demonstrations in eliminating the 3-day prior hospitalization requirement for SNF coverage. The purpose was to determine whether a waiver of the 3-day requirement would lower overall costs for both the patient and the medicare program. In addition, the contractors will determine if the 3-day requirement ordinarily imposes a burden on medicare patients who may need SNF care but not hospital care.

The SNF benefit is included in medicare part A to provide a lower cost alternative to extended hospitalization. The requirement of a 3-day hospitalization prior to admission to an SNF is imposed by the statute to limit SNF benefits to persons who need continuing care after hospital treatment. The requirement also insures that medical conditions and needs of medicare patients admitted to SNF's have been given adequate medical appraisal prior to admission. The Senate Finance Committee recommended that the Secretary of HHS conduct experiments to determine the effects of eliminating or reducing the requirement.

The experimental phase of the projects, which ended in 1980, tested the hypothesis that the 3-day prior hospitalization requirement has resulted in unnecessary hospital stays for medicare beneficiaries who could effectively use less costly SNF care without hospitalization. The contractors are also studying nursing home utilization and quality of care. Under the projects, approximately 28 facilities in each State have participated in the experimental part of the demonstrations, admitting a total of 970 patients during the first 2 years. During the experiment, all other criteria involved in the medicare SNF level of care decisions remained unchanged.

Use of the waiver option in Massachusetts and Oregon was low compared to the HCFA Office of the Actuary's national estimate of a 25-percent increment in SNF utilization. The Oregon waiver project accounted for 9 percent of the medicare SNF utilization in the 28 participating facilities during the demonstration period; for Massachusetts, it was 11.5 percent. Because some patients involved would have gone to the hospital and then transferred to SNF care afterward, the actual increment in nursing home utilization due to the waiver is somewhat less than these figures. The utilization rates for the two States were 19.2 and 11.8 waiver admissions per 100 beds in Oregon and Massachusetts, respectively; the number of waiver admissions per 1,000 medicare enrollees was 0.34 in Oregon and 0.75 in Massachusetts. Both States had similar experiences with respect to the length of stay. In Oregon, 79 percent of medicare-covered stays were less than 31 days in Massachusetts, 69 percent were less than 31 days. The average covered days under the demonstration varied between the two States: 26.1 days for Massachusetts and 23.3 days in Oregon.

The two States differed in sources of admission and patient diagnostic characteristics. In Massachusetts, 68.6 percent of all waiver admissions were internal transfers from a lower level within the institutions. Direct admissions from home represented another 23.9 percent, transfers from other nursing homes were 4.5 percent, and hospital transfers accounted for 3 percent. The composition of admissions differed in Oregon; only transfers from other nursing homes (6.4 percent) were close to the percentage found in Massachusetts. Home admissioons represented 36.2 percent of all admissions, 46.4 percent of admissions were internal transfers, and 11 percent were from hospitals.

Patient diagnostic categories differed for the two States. While fractures and amputations accounted for 26 percent of all admissions in Massachusetts, Oregon patients accounted for only 5 percent of admissions in these categories. This difference can be explained partly by the three chronic rehabilitation hospitals in the Massachusetts demonstration, two of which were entirely rehabilitative in their orientation; there were no facilities of this type in Oregon, which is more typical of the Nation.[1] The home admissions in Massachusetts occurred primarily in these rehabilitative facilities (73 percent of all home admissions), and the remaining home admissions were dispersed throughout the freestanding SNF's. Excluding the rehabilitation hospital cases, home admissions accounted for only 6 percent of all admissions. This difference was largely attributed to the better awareness of the demonstration by Oregon physicians and their more favorable attitude toward nursing homes.

---

[1] Of the 68 chronic rehabilitation hospitals in the Nation, 6 are in Massachusetts.

The most important aspect of these data is that the number of demonstration admissions over the 3-year experimental period are small in both States, 700 in Massachusetts and 648 in Oregon—11.5 and 7.4 percent of medicare SNF utilization, in the experimental facilities. These rates raise a key issue for evaluation: Can the same moderate level of utilization be expected if the program is expanded nationally, or is it a result of either the peculiar environment of each State or the way in which the demonstrations were implemented?

Each demonstration has been explored preliminarily in terms of its environment and special characteristics to identify specific factors that distinguish the two demonstrations and account for the utilization experience that was lower than expected. The low overall utilization can be attributed to the medicare SNF admission criteria, the physicians' practice patterns, and bed shortages. The major factor that would increase utilization of the medicare SNF benefit in a nondemonstration setting is a reduction in the strictness of the medicare SNF criteria themselves, or in their enforcement by intermediaries or PSRO's. This reduction, however, would affect direct entry and prior hospital stay entry equally.

Finally, not all increases in medicare SNF utilization led to reductions in hospital utilization. Evaluation interviews suggested that between 35 and 67 percent of the waiver patients probably would have entered a hospital if the waiver option had not been available. Thus, it appears that the waiver option will result in some increases in medicare SNF costs, but the degree to which these will be offset by reduced hospital stays is not clear and requires further analysis. The cost analyses will assess the cost of the waiver with respect to medicare reimbursement for SNF care and will estimate the potential hospital savings to assess the net cost of the waiver of the 3-day hospitalization stay prior to SNF admission requirement.

The evaluation contract was awarded to Abt Associates in September 1979. Final reports from the demonstrations will be available by the end of 1981.

THE SOCIAL/HEALTH MAINTENANCE ORGANIZATION CONCEPT

ORDS awarded a 3-year planning grant to the university health policy consortium at Brandeis University in spring of 1980 to develop a concept of a social/health maintenance organization for long-term care. The social/health maintenance organization is a capitation financed delivery approach to meet the needs of the disabled and/or elderly. It is designed to address two of the most pressing problems in long-term care: (1) The fragmentation of services, and (2) the fragmentation of funding sources. The concept promises to integrate health and social services as well as acute care services.

The objectives of the planning grant are multifaceted and include the following: (1) To provide technical assistance to several possible demonstration sites; (2) to develop the methodology for estimating utilization rates and for calculating costs and capitation rates; (3) to coordinate development of the data system and evaluation plans to insure maximum test results; (4) to develop criteria for selection of the demonstration sites; and (5) to link the evaluation of social/health maintenance organizations to other long-term care demonstrations.

A social/health maintenance organization (S/HMO) is an approach to the organization of health and social services in which an elderly population, which include those at high risk of institutionalization is voluntarily enrolled by a managing providers into an integrated service system. All basic acute hospital, nursing home, and ambulatory medical care and personal care support service including homemaker, home health, and chore services would be provided by or through the S/HMO at a fixed annual prepaid capitation sum. Other offered services would include emergency psychiatric, meals (home delivered and/or congregate), counseling, transportation, information, and referral. The provider may either employ staff or establish contracts with other providers for the services. In the S/HMO model, financial, programmatic, case decisionmaking and management responsibility rests with the provider entity. The S/HMO provider will share risk for service expenditures and will act as broker for other needed noncovered services which are available from other community providers. Financial risk is defined as absorption of agreed-upon costs which exceed a capitation agreement.

In comparison with other models, the S/HMO integrates health and social services under the direct financial management of the provider at the point of services delivery. The success of conventional HMO's with medicare contracts and of other managed systems of care (e.g., Triage and Monroe County models) has suggested the possibility of expansion to an S/HMO system model.

In the proposed demonstration, the S/HMO will serve persons from a targeted elderly population ranging from the ambulatory, nonimpaired aged to those who are extremely impaired. Inclusion of the well-ambulatory permits preventive activities for a population which feeds both hospital and nursing home utilization. Early management is expected to result in a delay or reduction in nursing home care. For such a population, survey data indicate that approximately 55 percent are ambulatory and well, 25 percent are ambulatory with modest home care needs, 15 percent are living at home with severe impairments, and 5 percent are very impaired, whether housebound or in nursing homes. While the S/HMO is expected to represent all four groups, the proportion enrolled will depend upon the attractiveness of the program to different groups and the intake procedures established by the S/HMO.

Financing for the S/HMO will flow from some combination of public funds (e.g., medicare, medicaid, and title XX), as well as from private payments, deductibles, and potential, private, third-party payers. Reimbursement would be on the basis of prepaid capitation.

The S/HMO will offer incentives to all involved parties. Incentives to the provider organization, for example, include improved cash flow, reduction in the cost of administering third-party billing mechanisms, flexibility in program innovation, financial incentives through negotiated rate ceilings and flexible savings arrangements, greater organizational stability, and growth potential in the long-term care marketplace. Public authorities will gain by harnessing HMO control methodologies to long-term care. The uncontrolled, or diffuse, long-term care costs can be addressed systematically through an integrated financing plan with provider risk-sharing and reduced administrative complexity. Consumers will benefit by having a single entry access to a wider range of services. These services will be provided in an integrated manner, thus reducing the need and costs of "shopping around." Paperwork usually associated with medicare will be eliminated.

It is hypothesized that the S/HMO will reduce the number of expensive institutional days for enrollees as well as encourage significant changes in utilization patterns.

Three S/HMO demonstration sites, to be selected, will provide a strong comparative evaluation of different S/HMO modes of organization. They will use common assessment instruments, comparable experiment populations, compatible management information systems, and a common evaluation strategy. The demonstrations will provide answers to questions about cost/benefit effects of a S/HMO, the effects of integrated care on the elderly and on service costs, the administrative feasibility of the S/HMO model compared with the fee-for-service model, and the effects on quality of care.

ON LOK COMMUNITY CARE ORGANIZATION FOR DEPENDENT ADULTS

The On Lok Community Care Organization for Dependent Adults (CCODA) is a community-based demonstration providing long-term health and health-related service to functionally disabled elderly in the Chinatown-North Beach area of San Francisco who meet the State's eligibility criteria for 24-hour skilled nursing or intermediate care, and who are medicare-entitled. A multidisciplinary team comprehensively assesses and reassesses the needs and strengths of each CCODA participant and develops a service plan to meet the individual's needs. The On Lok program delivers all services that are required either by their own staff or providers under contract. Single source reimbursement is provided under HCFA's title XVIII waiver approval. The Division of Health Services Studies, Office of Direct Reimbursement, provides the fiscal intermediary function for the project. A research and development grant (No. 18-P-00156) is concurrently funded by the Administration on Aging (AoA).

The objectives of this demonstration are: To develop and operate a centrally funded and administered community care system; to measure the impact of capitated funding on utilization, quality, and cost of services; to contrast the management efficiencies of the model with those of other systems; and to develop actuarially sound budgeting methods for medical and social needs.

The demonstration is now in its third of 4 years. During the first year, On Lok established the outpatient service delivery and reimbursement phase of the deminstration. This entailed a complete reorganization existing staff and their functions, hiring and orientation of additional staff, changes in procedures, changes in clinical and fiscal recordkeeping, validation of assessment instruments, further development of the research protocol and the establishment of data collection and analysis techniques. In addition, the transfer of the participants from the previous On Lok program to the CCODA required extensive time and effort due to the age and ethnic background of the population. The inpatient phase of the project was begun on February 1, 1980, with services provided through negotiated contracts with two hospitals and several skilled nursing facilities in the area. By February 1981, the CCODA program had essentially completed its developmental phase and entered a stage of normal operation.

On Lok currently serves approximately 20 participants who have an average age of over 78, who are mostly of Chinese descent, with slightly more males than females, just over one-half living alone, and with 87 percent having monthly incomes under $500. The current per capita cost is $31.30, with $939 as the average cost per user per month. These costs include outpatient services (day health, transportation, primary medical care, drugs, medical specialty services, home health, etc.) and institutional (hospital and skilled nursing facility) care.

The research component of On Lok funded by AoA has a program-based policy-oriented perspective with the primary objective of assessing the impact of the CCODA program on the quality and cost of long-term care. The research (1) includes process evaluation, that describes and interprets issues and problems in program development and operation; (2) has developed and continues to refine, a computerized information management system that (a) is used in program operation; (b) monitors information on a regular basis for program administration and development; and (c) establishes a real-world-relevant data base for research analysis; (3) has established and maintains a comparison group study, identifying a sample of similar elderly in the traditional long-term care system and tracking them over time, gathering information comparable to that in the information system to assess relative program impact. This study has a sample size of 160. Cost analysis is a specific area of focus in the current year with participant-based predictors of the cost rate (e.g., functional level, physical and social characteristics, biographical data, etc.) being identified, and the proportion of monthly CCODA costs that would be reimbursable under existing programs (e.g., titles XVIII, XIX, XX) being determined.

HCFA is evaluating the On Lok CCODA through the crosscutting evaluation of its long-term care demonstrations. This evaluation contract was awarded to Berkeley Planning Associates in September 1980.

SKILLED NURSING PHARMACY SERVICES—CAPITATED REIMBURSEMENT

ORDS awarded a grant in 1979 to the California Department of Health Services to conduct a pilot project on capitated reimbursement of drugs for medicaid paisters a program of medical assistance under title XIX of the Social Security Act. The objective was to improve the drug regimen of medicaid SNF patients, which in turn should improve the overall quality of care and reduce costs.

The California State Department of Health Services (DHS) currently administers a program of medical assistance under title XIX of the Social Security Act. The program provides a broad range of medical services to a beneficiary population that is predominantly categorically linked. Medicaid usually pays for these services on a fee-for-service basis. Approximately 2.5 percent, or 67,500, of the nearly 3 million beneficiaries receive their care in skilled nursing facilities (SNF's). Medicaid payment for health care for these beneficiaries is made to the individual provider of service, e.g., SNF, physician, dentist, physical therapist, pharmacist. To control utilization of pharmacy services, medicaid has employed a closed formulary, that is, a specific list of covered drugs, with prior authorization required for unlisted therapeutic agents. Current costs of pharmacy services for SNF inpatients average approximately $26 per patient per month. To determine if there are ways that the current expenditures for drugs for SNF patients in the medicaid program can be reduced, the California State Legislature enacted Assembly bill 1395. The legislation authorized a pilot project in which pharmacists would be reimbursed on a capitated basis for pharmacy services provided in SNF's.

The project proposed to establish capitation rates for 30 selected SNF's based on 25 pharmacies' experiences with those facilities. The monthly capitation rate would be calculated for each facility and would be paid to the pharmacy in advance for each medicaid patient served by that pharmacy in the following month. In addition, pharmacists who participated would be granted the authority to approve nonformulary drugs necessary for the treatment of the patients.

Participants were to be selected to reflect the geographic and bed size distribution of nursing homes in the State. Contracts were prepared to establish project requirements with the participating pharmacies. A group of pharmacies and SNF's was selected for comparison purposes. The project was planned to be a 3-year effort with a 1-year, precapitation period for selection participants, collecting baseline data, determining rates, and developing the evaluation methodology.

The project would have allowed the pharmacist to bypass the usual utilization controls of the medicaid program and to exert his or her professional judgment to a maximum degree, consistent with a high quality of care. Minimum quantity requirements, prescription audits, and diagnosis restrictions would have all to be waived for the patients served under this project. In the summer of 1981, the legislature passed a law eliminating the closed formulary.

A two-part evaluation of the project results was planned. The State will evaluate the changes in costs and utilization of services which result, if any. An outside contractor second evaluation, using a multidisciplinary team of physicians, pharmacists, pharmacologists, and nurses to evaluate the professional decisions involved in the treatment authorization request (TAR) approval process as well as the overall quality of care received by the patients.

Several methods of setting capitation rates were tried. None was successful in convincing pharmacists that they would not lose money over a fee-for-service method. The one upon which the State and State Pharmacists Association agreed attracted only six pharmacists to the project. It had been determined that at least 20 would be required to carry out the project. Therefore, the State requested termination of the project in the fall of 1981.

A final report detailing the methodology, various capitation ratesetting methods, the evaluation process and the problems encountered will be available in spring 1982.

CAPITAL INVESTMENT IN NURSING HOMES

In August 1980, ORDS awarded the West Virginia Department of Welfare a section 1115 grant. This allowed waiver of the current methodology for determining capital costs included in the medicaid reimbursement of skilled nursing facilities and intermediate care facilities. The basic objective of this demonstration is twofold:

—To determine whether the proposed reimbursement system produces satisfactory patient care within the operating cost standards; and

—To determine whether the proposed system results in lower reimbursement rates when compared with a system of reimbursement based on historical costs for all service factors (for example, a medicare formula).

There is reason to believe that controlling cost-by-cost center is preferable to an aggregate operating cost cap, but the data required to evaluate this hypothesis are not currently available. This project will, therefore, focus upon the investment component and the total reimbursement rate under the following operational assumptions:

—Functional and physical variances from the model facility standard result in operational and nursing services deficiencies, inefficiencies, and diseconomies.

—Quality of care is insured and verified through review of the monthly long-term-care services invoices and quarterly nursing services audits.

—Both the rates of reimbursement and the manner in which they are determined significantly affect investor confidence in the industry and the quality of services provided.

Given these assumptions, West Virginia has implemented two parts of a three component reimbursement system. The *nursing services component* is compensated on the basis of actual nursing services required by and delivered to individual patients. The *operating costs component* is compensated by cost center and facility class. Caps on operating costs will be derived from industry experience within the State. Incentives for efficiency and economy will be introduced through the operating cost component by encouraging costs less than the cost caps, with quality of care assured and verified. As a management incentive, the

State will share with the facility any savings when actual costs fall below established caps. That incentive will consist of a percentage of the difference between actual facility cost and the established cost caps, provided such facilities meet all certification and quality patient care standards.

The *investment component* of the new reimbursement system (which is being implemented under this demonstration) should allow for the reasonable costs of investments in long-term care facilities, including a reasonable return on the investment. A unique aspect of this system is the method for determining the allowance for value of the investment component (land, building, and equipment) of the reimbursement rate.

The standard appraised value (SAV) method establishes the value of the fixed assets *as a long-term care center*, thereby discouraging features which detract from or do not contribute to that function and encouraging functional utility. The model facility standard is drawn from Federal and State regulations and guidelines and from accepted industry practice and offsets the fundamental difficulty of the reproduction cost approach by providing a stable base for deriving consistent appraisals of long-term care properties.

The tasks completed in the first year included the design and implementation of uniform accounting and reporting procedures, definition of the model facility standards, initial appraisals of all facilities, the evaluation of the appraisals and the establishment of a rate of return. In designing the reimbursement formula, the State based the rate of return on the yield generated by the Federal National Mortgage Association's (FNMA) conventional mortgages. It is felt that this yield will allow enough flexibility to keep current with the recent volatility in the mortgage market. Implementation on a statewide basis was affected in April 1981. Since this project has just begun, no findings are available at this time. It is hoped that this different method of reimbursing capital costs will discourage rapid turnover in facility ownership and encourage greater stability.

INCENTIVE PAYMENT GRANT

"Encouraging Appropriate Care for the Chronically Ill Elderly"; Grant awarded to the State Department of Health, Sacramento, Calif.

Early in 1981, approval was given for a section 1115 waiver grant to the Department of Health Services in Sacramento, Calif. The purposes of this 2-year grant are to improve appropriateness of care and encourage more efficient use of resources through: (1) Encouraging nursing homes to admit sicker patients who require more care and who might otherwise remain inappropriately hospitalized; thus encouraging unnecessarily high costs for care; (2) improving resident's outcomes through improved quality care facilitated by resident-specific goal setting and care planning; and (3) encouraging discharges of certain kinds of residents who might be served more appropriately by noninstitutionalized services thus making room for more severely dependent patients.

The total costs (estimated at $3 million) of the project will be paid through contract No. 233–79–3019 between the National Center for Health Services Research (NCHSR) and Applied Management Sciences, Inc., dated September 29, 1979. The contractor will reimburse participating facilities for data collection and incentive payments earned under the study protocol. The contractor will pay for all other data collection and data processing activities, including data supplied by the California Department of Health Services. Analysis of the data and final reports will be completed by the NCHSR.

Methodology

Thirty-six proprietary nursing homes in the San Diego SMSA, having between 50 and 200 beds, with at least 50 percent normally available to Medi-Cal residents will participate in the study. The homes were randomly assigned to treatment or control groups. It is estimated that 3,472 residents will participate in the demonstration, one-half in the experimental and one-half in the control homes. The demonstration will attempt to encourage long-term care facilities to admit and provide quality care to severely dependent residents, and to discharge less dependent residents into lower levels of care or to provide continuity of care for discharged residents.

—Nursing homes will be paid an incentive payment for admitting severely dependent residents.

—Outcome incentive payments will be paid for achieving specified outcome goals in selected patients who require special care to improve or maintain their functional health status.

—Incentive payments will be paid for discharging residents who should be discharged (must be kept at a lower level of care or in the community for at least 3 months).

—No incentives will be paid for residents who should not have been admitted or for those expected to have a stay of less than 90 days.

Data will be collected by Applied Management Sciences and analyzed by NCHSR staff. Final reports should be available early in 1984.

QUALITY ASSURANCE

SURVEY-BY-EXCEPTION (SBE)

In July 1980, a section 1115, waiver-only, quality assurance grant was awarded to the Massachusetts Department of Public Welfare. The purposes of this 18-month project are to reallocate surveyor time so that facilities with the greatest certification compliance problems can receive additional consultation and technical assistance by the surveyors and to improve the quality of care in skilled nursing facilities (SNF's) and intermediate care facilities (ICF's).

This project will test an experimental facility survey process in medicaid and medicare facilities. The medical review (MR) and independent professional review (IPR) patient surveys will be performed as usual. Massachusetts has developed a facility screening instrument which it will be pretested for reliability and validity before using it in the demonstration.

Methodology

The facility survey is a modification of the screening survey developed by the Wisconsin quality assurance project. The design for the demonstration classifies facilities into three groups, based upon their performance on annual surveys for the preceding 3 years.

The Massachusetts long-term care information system (LTCIS), a management information system containing the results of all facility surveys since 1976, aggregates survey results at the facility level so they can be compared across facilities. The criteria for facility classification are as follows:

—Screening survey group—compliance scores of 93 or above on annual inspections for 3 calendar years prior to the inspection date (classified as outstanding).

—Abbreviated survey group—compliance scores 85 or above for the past 3 calendar years (classified as acceptable).

—Full survey group—compliance scores below 85 for the past 3 calendar years (classified as unacceptable).

The demonstration is planned as a 2×2 experimental design with test facilities in outstanding and acceptable groups assigned randomly to the traditional method of survey and the SBE method.

The design calls for 120 of the 160 facilities in two geographic areas, the northwest and southeast sections of the State, to be assigned to the four cells of the design; 60 will be eligible for SBE and 60 will receive the traditional survey.

Hypotheses to be tested include the following:

—Quality of care in the screening and abbreviated survey facilities in the experimental groups will increase or remain constant relative to screening survey and abbreviated survey facilities in the control group.

—Quality of care will improve in the full survey facilities.

—Time spent on certification visits will decrease in facilities in the abbreviated and screening survey groups.

—Time spent on certification visits will increase or remain constant in the poor performance group.

—The number of interim visits, followup visits, and consultation visits, and the time spent on such visits will increase in each of the three groups.

—Provider attitudes toward the State survey agency will be more favorable in facilities participating in SBE.

The demonstration was initiated October 1, 1980, following completion of pretesting and compliance with conditions attached with the notice of grant award.

In October 1981, the demonstration was expanded statewide. Outstanding facilities, 146 in number, will receive a quality of patient care screening survey involving 64 areas of concern. Satisfactory facilities (293 in number) will receive an abbreviated survey covering 54 "core" regulations and traditional survey of any area where a definciency is found, such as the dietary department. The original control group and all other facilities will get a traditional survey.

This demonstration will be evaluated by a contractor chosen by HCFA to evaluate all of the survey/certification-related demonstrations.

Findings to date:

—SBE decreases the amount of time spent on certification visits.

—Surveyors spend more time on consultation and followup visits.

—The number of "trivial" deficiencies declined with SBE.

IMPROVING NEW YORK STATE'S NURSING HOME QUALITY ASSURANCE PROGRAM

The New York State Department of Health was awarded a section 1115 waiver-only grant, effective September 2, 1980. This 3-year demonstration is part of an overall effort by the State to improve the quality of care provided in residential health care facilities (RHCF's), which include both skilled nursing facilities (SNF's) and intermediate care facilities (ICFs).

DESCRIPTION

The objectives of this project are to simplify and streamline the medical review (MR) and independent professional review (IPR) for all RHCF's in New York State. The current system is described as very cumbersome, particularly when 8,000 reviews are processed per week. The new system will use a screening survey (based upon the screening survey developed for the Wisconsin quality of care project). It will combine a form to be filled out by the facility with a relatively brief form to be filled out by the reviewers when they visit the facility. This latter form would reduce the number of items for the SNF survey from 1,285 to 241 and the ICF requirement from 780 to 223. MR and IPR will be combined into a single process. The first stage will be an outcome-oriented system which will look at sentinel health events (SHE"s). These are defined as untoward events whose presence represents a potential failure in the care system. Examples include the presence of these events exceeds a threshold (to be established on the basis of the patient mix and the facility), then the second stage of the process will be initiated. In the second stage, a more detailed investigation of the process of care for a sample of patients having the untoward events will be undertaken using specifically designed protocols for each SHE.

The research design assesses three things: (1) Review of the 20 percent of facilities requiring intensive surveys, (2) the validity of the outcome-based screening and the process-based followup, and (3) the causes of deficiencies in the new process. Finally, it will apply various statistical measures to test the increased efficiency of the new system over the old one.

Hypotheses to be tested include:

—The survey emphasis on the structural measures of quality of care will complement the outcomes/process measures of the MR/IRP to more clearly define the causes of lack of facility compliance with State and Federal regulations. Corollaries of this hypothesis are: The deficiencies in the new process will be traced to underlying causes rather than symptoms to a greater extent in the new system than in the old; and the plan of correction filed by the facilities will treat underlying causes rather than symptoms to a greater extent in the new system.

—Each SHE is a reliable measure.

—The SHE's will point to areas of poor quality care.

—Different reviewers will reach the same decision as to whether a stage II review is needed.

—Stage II review reliably and efficiently documents poor quality care when compared to the present system.

—The new system will document more problems associated with direct patient care rather than indirect factors related to patient care.

Work accomplished to date: (1) HCFA attached several conditions to the grant award and these were all satisfactory completed; (2) two field tests of the SHE's have been completed which resulted in revisions of the definitions and protocols for measuring the SHE's; (3) an educational curriculum for surveyors has been developed and training programs have been evaluated in the State; (4) 300 State agency personnel and 500 provider representatives have been educated regarding the new methodology.

The project was implemented in the upstate New York areas of Albany, Buffalo, Rochester, and Syracuse in July 1981; the downstate areas of White Plains and New York City followed in October 1981.

The project will be evaluated by an independent evaluator chosen by HCFA.

QUALITY ASSURANCE

NURSING HOME QUALITY ASSURANCE PROJECT (QAP)

The Wisconsin Department of Health and Social Services is in the last year of a 4-year, section 1115, waiver, only project to improve the quality of care in nursing homes using an experimental survey and certification methodology. This demonstration is based on the premise that the State should reallocate surveyor time so that more time is spent in nursing homes that are cited as having deficiencies and less time in nursing homes providing good care.

Project Objectives

The primary goal of the project is to improve the quality of care in nursing homes in the demonstration areas using cost-effective techniques which reallocate the State's resources.

To increase the efficiency and effectivness of the facility review proecss, QAP does the following:

—Uses a screening technique which allows teams to separate homes into three categories—homes performing well; homes with minor problems likely to be resolved with consultation; and homes with one or more serious problems requiring detailed analysis for possible negative action.

—Omits the full facility survey except where indicated by a history of problems or after using the new facility screening technique.

—Involves nursing home administrators and rehabilitation specialists in the facility survey to provide a broader base of knowledge for the evaluation.

—Trains survey staff to collect data which will hold up in court when negative action is indicated.

—Schedules survey visits at less predictable and more frequent intervals to collect more accurate data.

To increase the efficiency and effectiveness of the medical review (MR) and independent professional review (IPR) of patient care, QAP:

—Uses a statistical quality control methodology to choose a stratified sample of patients for *intensive* review, rather than performing a cursory review of all patients currently in the home.

—Reallocates staff time to comprehensively evaluate the home's *system* for identifying and meeting patient needs.

—Omits the full MR and IPR survey except where indicated by a history of patient care problems or after using the new patient sampling technique.

—Provides feedback to the facility survey by citing deficiencies and documenting cases of poor patient care for court use.

To improve the quality of nursing home care by resolving the problems discovered through the facility survey and patient review, QAP has done the following:

—Developed criteria for quickly choosing corrective actions from a list ranked by severity.

—Added new options to the list of correction/enforcement actions, includinng consulting with survey team members and contracting for technical assistance.

—Provided more immediate feedback to homes detailing deficient areas of patient or institutional management, especially for homes evaluated as needing enforcement action.

Since these last three elements are considered essential in any quality assurance system, they are used in both control and experiment sites. The experimental design separates the effect of these changes from those caused by the experimental facility and patient review processes.

Methodology

The bureau of quality compliance, Wisconsin Division of Health, is demonstrating two new approaches to the control of quality in nursing homes. These approaches deviate from traditional State and Federal requirements. The first requirement is that a nursing home be evaluated for compliance with applicable State and Federal regulations at least annually. The second requirement is that every medical assistance nursing home resident be evaluated at least annually for appropriateness of placement and level of care.

Facility Screening

In place of existing requirements for annual surveys of nursing homes, a screening survey to quickly identify problems in critical areas is being tested. Further action, ranging from informal consultation to decertification is taken on problems found during screening. The time saved through this screening process is allocated to more rigorously pursue enforcement in homes that are endangering the health of their residents.

Sampling Patient Review

In place of existing requirements for reviewing medical assistance recipients in nursing homes, a scientifically chosen, 10 percent sample is taken of all patients in the home. As in the facility screening, decisions for further action are based on problems found during the careful review of this sample. State surveyor time saved by not examining all patients is devoted to more extensive consultation and enforcement.

In July 1978, during the first phase of the demonstration, Wisconsin studied 122 facilities (SNF's and ICF's) in a rural area using a 2x2 factorial design of the treatments, facility survey, and patient evaluation. The two options for facility "treatment" are the old full survey and the new screening survey; the two options for the patient "treatment" are the old 100 percent medical review and the new patient sampling technique.

In the second phase of the project, Wisconsin added 40 more homes in a large urban area to the demonstration. In half of these nursing homes, the screening survey and patient sampling techniques were used, and in the remaining 20, the old full survey and 100 percent medical review were carried out. In addition, another 20 homes were selected as control homes in the urban area.

Two additional changes were made in the second year which affected the demonstration methodology. First, HCFA approved a waiver of the life safety code, so that a screening survey instrument could be used by the engineer/architect. Second, the health standards and quality bureau approved receiving less than the full report for title XVIII certified facilities which resulted in the inclusion of these facilities in the demonstration.

In the last phase of the demonstration, 40 additional facilities were added to the sample. These facilities are located in a mixed rural/urban area of the State. The methodology has been slightly changed in the last phase to further eliminate the possiiblity of surveyor bias. In these areas, separate survey teams have been assigned to each treatment cell. One team uses the screening survey and patient sampling methodology and the other, the full survey and 100 percent patient sampling.

With this last expansion, the demonstration project includes 31,000 resident/patients and 281 (59 percent) of the State's nursing homes.

Findings to date include the following:

—The total time for survey and certification visits using the screening survey and 10 percent sampling of patients for MR/IPR is 2 days in homes of 100 beds or less, while the traditional methods in homes of the same size require 15 working days.

—The State survey staff and nursing home administrators and staff have positive attitudes about the screening survey and sampling technique.

—The number of nursing home administrators serving on the screening surveys has increased but has not yet reached 100 percent.

—Surveyors are making increased use of the option to switch from the screening survey to the traditional method. The most common reasons cited are a poor survey record, a new administrator, or a new director of nursing.

—Surveyors in the rural districts make more frequent surprise visits than those in the urban areas.

—Surveyors using the new methods spend proportionately more time on facility assessment than when using the traditional method, less time on resident assessment, and only a slightly greater proportion of time on followup.

—When the new methods of survey and certification are used, slightly more class A violations (probably of death or injury to a patient) and slightly fewer class B (direct threat to health and safety) and class C (does not threaten health and safety) violations were found.

—Surveyors using the new methods make more frequent use of a variety of State followup actions, that is, consultation, special advisor, and return to followup.

—There is a lower percentage of patients observed to be at an incorrect level of care using the sampling methodology. However, after reviewing the history of facilities in the study, the QAP findings reflect preexisting differences in these homes.

A grant for an independent evaluation of the demonstration to the University of Wisconsin has been underway since July 1980 to the University of Wisconsin.

PUBLIC HEALTH SERVICE

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

National Institute on Alcohol Abuse and Alcoholism (NIAAA)

INTRODUCTION

Alcoholism is a serious health problem among the elderly. A recent NIAAA report, "Alcohol and Health," indicates that a significant number of people 60 years old and over have problems with alcohol. Loneliness, loss of spouse, physical or emotional separation from children, ill health, or lack of purposeful employment can precipitate alcohol problems in the elderly. Estimates of the number of elderly alcoholics range from 1 to 2.7 million.

An analysis of national surveys on alcoholism among the elderly indicates that the significance of this problem has only recently been appreciated. The majority of the problem drinkers aged 65 and over are unidentified, overlooked, and untreated. It has been estimated that about 85 percent of all elderly problem drinkers are not receiving any type of service related to their alcohol problems. One of the major barriers to treatment of alcoholic senior citizens is the failure to consider alcoholism as a possible diagnosis. What is perceived as frailty, senility, or simply the unsteadiness of old age may in fact be alcoholism. Relatives, friends, and service professionals working with the elderly may be reluctant to acknowledge the need for alcoholism treatment. In addition, social agencies for the aged usually are poorly equipped to treat alcohol problems, and many alcohol treatment centers are geared to a younger clientele.

Restricted medicare coverage is an additional stumbling block to the treatment of alcohol-related problems among the elderly. Almost all of the elderly depend to some extent on medicare to pay for health services. Medicare is, however, a health insurance program designed to pay for inpatient care and physician services. Most of the nonphysician health and social services that are part of comprehensive alcohol treatment programs are not covered by medicare.

NIAAA has a legislative mandate to encourage and give special consideration to the submission of project grants and contracts for the prevention and treatment of alcohol abuse and alcoholism among the elderly under section II of Public Law 96–180. In response to the recognized needs of the elderly and the legislative mandate, NIAAA has initiated a number of special activities targeted to this population. These activities are described in the following narrative.

INTERAGENCY ACTIVITIES

NIAAA, in cooperation with the Health Care Financing Administration, has undertaken a major demonstration program to improve medicare and medicaid coverage for alcoholism treatment services. NIAAA provided $1.1 million in fiscal year 1981 to fund demonstration grants for the purpose of demonstrating the feasibility and cost effectiveness of providing alcoholism treatment services in freestanding residential and outpatient settings, including halfway houses, as alternatives to services currently covered by medicare and medicaid.

Other interagency activities initiated in fiscal year 1981 include:

—Participation in the White House Conference on Aging to highlight the alcohol-related problems of the elderly and to stimulate social concern in this area.

—Participation on the National Council on Alcoholism Blue Ribbon Committee on Aging and Alcohol.

—Dialog with the Administration on Aging to explore cooperative activities.

TREATMENT

The elderly are receiving alcoholism treatment services throughout the country through most of the programs currently funded by NIAAA, with the exception of programs specifically designed for youth. These programs offer such services as outreach, referral, counseling, detoxification and other forms of treatment on an inpatient, outpatient or day care basis.

In addition, NIAAA presently funds one program specifically designed to meet the needs of the elderly who are experiencing difficulties with alcoholism or other alcohol related-problems. NIAAA provides approximately $237,128 per year for this program. The program is located in Vancouver, Wash.

The Vancouver senior alcohol services project is administered by the Health and Welfare Planning Council of Clark County, Wash. The program is targeted for both men and women 60 years of age or older who live in Clark County and who have a problem with their use of alcohol. The program is also available to provide services to the drinking person's relatives or friends who are concerned with and/or affected by that person's misuses of alcohol. The program meets needs beyond alcohol treatment in such areas as nutrition, health, transportation, and other daily living activities. The program provides training in alcoholism and gerontology and evaluates the treatment and training efforts. In addition, research is being conducted on the drinking patterns of both alcoholic and nonalcoholic elderly persons.

RESEARCH

During fiscal year 1981, the NIAAA Division of Extramural Research granted a time extension to a funded pilot study in Los Angeles, Calif., to investigate alcohol drinking practices among the aging. The survey study will investigate the alcohol drinking practices in a sample of elderly community residents in Los Angeles County. Status changes which may be related to drinking patterns in this population will be examined in six life areas—work, family, social networks, economics, age, and health. Social annd psychological correlates of drinking patterns will also be assessed. These include life satisfaction, personal control or mastery, and tendencies to "give up" in dealing with problems.

During fiscal year 1982, the NIAAA Division of Extramural Research is planning to support a workshop on alcohol abuse among the aging, in collaboration with the National Institute on Aging. The workshop will enable investigators who are concerned with alcohol-related problems of the elderly to exchange information, serve as a forum for evaluation of ongoing research and provide future research directions. The proceedings and recommendations of the workshop will be published in the NIAAA alcohol research monograph series.

RESEARCH TRAINING

During fiscal year 1981, Division of Extramural Research funded one predoctoral fellow for training in the study of geriatric alcohol use.

Subsequently another fellowship application from a postdoctoral candidate who express interest in gerontology has been received and is in process of review.

CLINICAL TRAINING

During calendar year 1981, the NIAAA Human Resources Branch had two active training programs one of which was funded for $137,464 to train alcoholism service providers for the elderly.

One grant was awarded to the Mental Health Institute of Independence, Iowa, to improve the quality of service available to the elderly who have problems with alcohol. The program will provide training for health and social welfare personnel, and attempt to develop a training model for use by other programs. Specialized training in the alcohol problems of the elderly will be offered to such service providers as policemen, firemen, AA members, volunteer workers, health and social welfare personnel, and alcohol counselors.

The second grant was awarded to the School of Social Work of Adelphi University in Garden City, N.Y. The purpose of the grant is to train social work students in serving alcoholics residing in single room occupancy hotels located in the Upper West Side of Manhattan, N.Y. This project will put special emphasis on developing training approaches for intervention with the aging and aged alcoholics.

The Human Resources Branch continued its focus on the development of programmatic activities for primary care physicians. The elderly population is a component of this set of activities.

Through its contractor, the National Center for Alcohol Education, NIAAA is developing prevention education materials for the elderly. The materials will be produced in a handbook format with a companion curriculum guide in fiscal year 1982. The will contain information about the effects of alcohol on the body, psychologically and physiologically; the influence of the aging process on consumption, the impact of changes in lifestyle on customary drinking behavior; for example, retirement, change of geographic area, and loss of companionship. These materials will be targeted to staff of residencies for the elderly, senior neighborhood centers, and nursing homes. This project will be coordinated with Elder-Ed, an audiovisual training program developed by the National Institute on Drug Abuse, which presents material on the use of alcohol with prescription drugs.

NATIONAL INSTITUTE ON DRUG ABUSE (NIDA)

One of NIDA's primary objectives in fiscal year 1981 was to gain a clear understanding of the nature of the drug problem among the elderly. Programmatic efforts in this area were directed toward that end. The Institute's management system reported little illicit drug abuse among older Americans. In fact, the client-oriented data acquisition process (CODAP) showed that only 0.3 percent of all clients admitted to federally funded clinics were 65 years of age or older in 1980. This confirmed a trend observed over the past few years.

On the other hand, data collected from a variety of other sources strongly suggested that the elderly's drug problem stems less from substance *abuse*, than from drug *misuse* involving the inappropriate consumption of an assortment of prescription and over-the-counter preparations. Clearly, the elderly's higher functional disability and their social isolation put them to great risk to use medications for reducing the critical stresses of their advancing years. The Institute views the potential dangers as very real.

The aging are a rapidly growing population. Americans 65 or over now number more than 26 million and constitute an important national resource. Demographic projections indicate that individuals in the 65 and over group will increase to 32 million by the end of this century and by the year 2030 will number 56 million or almost 18 percent of the U.S. population. Although they presently comprise only 11 percent of the populace, they consume about one-fourth of all prescription medicines.

In fiscal year 1981, NIDA supported various projects targeted wholly or in part toward the aged. An estimated $489,000 was expended on research, prevention, training, treatment, and interagency activities in this area.

RESEARCH

During the past year, the Division of Research began preparing a research monograph tentatively entitled "Drug Use, Misuse, and Abuse Among the Elderly." The volume will contain three sections—a bibliography of 500 to 600 major articles relevant to this area; one-page abstracts of perhaps 100 of the most important of these articles; and a synthesis or summary chapter written by various authorities in the field.

A completed study of a NIDA-sponsored survey of noninstitutionalized elderly persons, age 55 years or older, was recently received by the Treatment Research and Assessment Branch. Of 1,101 persons surveyed in Houston, Tex., 17.6 percent were using prescribed psychotoropic drugs at the time of the interview. About 6.9 percent of the total sample were found to deviate from their treatment schedules. Over four-fifths of these deviators took less medication than prescribed but only 13.2 percent of this group exceeded their prescription dosages. Finally, only 1.9 percent of the entire sample reported ever having used an illicit substance. Based upon this analysis, the authors concluded that the misuse of psychotropic drugs by elderly populations is not a significant drug abuse concern. It should be noted that earlier studies yielded varied conclusions.

PREVENTION/TRAINING

NIDA's prevention programs for older persons are primarily educational in nature and are directed toward the appropriate use of prescription drugs. One such program, "Elder-Ed: Wise Use of Drugs for Older Americans," is designed to assist the elderly in making the best use of their medicines. A film and two booklets make up an attractive prevention kit. The film deals with the doctor-patient relationship and with the common problems associated with the use of medication. The two booklets sum up the information given in the film and provide space to list medicines and emergency medical information for the family physician.

Wide dissemination of Elder-Ed by NIDA has produced some satisfying results. For example, a consortium of six States has developed a task force called "Keys to Help the Aging." These States are: Alaska, Arizona, Idaho, Nevada, Utah, and Wyoming. The aim of the task force is to promote healthy lifestyles for the elderly by mobilizing their interest in workshops and networking. When in full operation, it will train well-adjusted seniors to work with less-adjusted seniors to help ameliorate those feelings of isolation and diminished self-worth which often lead to emotional reliance on drugs. Tenna Kirsher, the State prevention coordinator of Idaho, is the spokesperson for the group. Some of the expenses associated with the early development of the task force were absorbed by the regional support centers of NIDA's division of training. Technical assistance was provided by the prevention branch's pyramid project.

TREATMENT

Slightly fewer than 700 persons aged 65 or older were admitted to NIDA-supported drug abuse treatment centers last year. Although the figure is quite low, the total indicates that at least a small portion of the elderly does engage in the more familiar forms of drug abuse. How large the undetected population may be is difficult to assess.

INTERAGENCY ACTIVITIES

In fiscal year 1981, the Institute signed an interagency agreement with the National Institute of Mental Health (NIMH) to analyze the latter's epidemiologic catchment area program data and determine drug consumption and abuse/misuse by the elderly. $60,000 were transferred to NIMH for that purpose to cover 1 year. In addition, NIDA also engages in the exchange of information with such agencies as the National Institute on Alcohol Abuse and Alcoholism, the Administration on Aging, the National Institute on Aging, and is presently providing expertise on drug abuse to the White House Conference on Aging.

NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

INTRODUCTION

Five percent of the Nation's aged live in institutions. Of these 5 percent, about 12 percent are in mental hospitals and the remainder in nursing and other types of homes for the aged and chronically ill. The elderly comprise 6 percent of admissions to State and county mental hospitals and 29 percent of the resident patients. Approximately 80 percent of those 65 years of age and older who live in nursing and personal care homes have some degree of mental impairment. Only 3.8 percent of outpatient psychiatric service admissions are aged 65 and over. An estimated 10 to 25 percent of the aged in the community have some degree of mental impairment. The death rate for suicide is highest at age 55 and over (18.5 per 100,000 as compared with 12.6 per 100,000 for all ages). Approximately 46 percent of all male admissions aged 55 and over to inpatient services of State and county mental hospitals had a primary diagnosis of alcohol disorders.

MENTAL HEALTH SERVICES FOR THE ELDERLY

In October 1980, Congress enacted the Mental Health Systems Act. In doing so, it noted that, despite the significant progress since the original community mental health centers legislation was enacted in 1963, there remained unserved and underserved populations within the mental health serbice system. Those populations included the chronically mentally ill, children and youth, and the elderly. For this reason, the Mental Health Systems Act directed specific attention to these groups. In four of its programmatic sections, there were key provisions for mental health services to the elderly.

The President's economic recovery program replaced the Mental Health Systems Act with a block grant program that provides flexibility to the States in administering Federal funds. In enacting the alcohol, drug abuse, and mental health services block grant, Congress continued the commitment to the unserved and underserved populations, including the elderly. The mental health portion of the block grant is to be used by States to fund community mental health center programs which provide the following services: (1) Outpatient services, including specialized services for the elderly, children, and chronically mentally ill; (2) 24-hour emergency care; (3) day treatment or partial hospitalization; (4) assistance to courts and public agencies in screening persons being referred to State mental health facilities; and (5) consultation and education services. In addition, a community mental health center providing the above services may receive funds from the State block grant for the identification, assessment, and provision of mental health services for the elderly.

The goal of the alcohol, drug abuse, and mental health services block grant is to place decisionmaking at the State level. The States will be able to use the Federal funds with greater flexibility in areas of greatest need.

CENTER FOR STUDIES OF THE MENTAL HEALTH OF THE AGING

Aging, though long a program area of the National Institute of Mental Health (NIMH), had received only limited support. This has changed in recent years, and the program has become nationally and internationally prominent.

Recent significant developments in the NIMH aging program are listed below in chronological sequence:

(1) 1975—establishment of the Center for Studies of the Mental Health of the Aging to coordinate Institute activities in aging.

(2) 1975–76—organization of three national planning conferences related to mental health and aging. These conferences helped establish the agenda for the Center. They dealt with research training and services.

(3) 1977—provision of $2 million in the supplemental appropriation for fiscal year 1977 to support research in mental health and aging.

(4) 1978—transmission to Congress of the report of the HEW Secretary's Committee on the Mental Health and Illness of the Elderly, as mandated in Public Law 94–63.

(5) 1978—issuance of the report of the President's Commission on Mental Health. In the report, the elderly were identified as a major underserved population.

(6) 1978—elevation of the Center for Studies of the Mental Health of the Aging from a coordinating unit to a fully operational entity with responsibility for administering research and training grants.

(7) 1979—identification of the aging as a priority target population for clinical training initiatives. This action was taken in accordance with the recommendations of the President's Commission on Mental Health.

The Center for Studies of the Mental Health of the Aging (CSMHA) is the focal point for aging programs in the Institute. The major role of CSMHA is to stimulate, coordinate and support research, training and technical assistance efforts relating to aging and mental health. The Center staff consists of eight professional and four support staff members and one visiting scientist.

Documentation of the progress made by the Center in the development of its program is provided below. Activities of the Center fall into four categories: research, research training, clinical/services training, and nursing home improvement.

1. Research

The Center supports those studies which have a primary focus on the mental health and illness implications of the aging process and of old age. A wide-ranging, multidisciplinary set of theoretical, applied and policy studies is funded. Almost all of the Institute's research support programs are involved in this NIMH/ADAMHA-wide, coordinated effort. In this way, NIMH has not only mounted a targeted effort in aging through its Aging Center, but has also brought the strengths of all its generic programs to bear on mental health and aging programs. In addition, the Center has been active in stimulating collaborative efforts between different Federal programs and agencies. Diverse strengths and limited funds are brought together through the program coordination plan developed by the NIMH Center for Studies of the Mental Health of the Aging. The Center's research program includes the following subjects:

—Causes, treatment, and prevention of Alzheimer's disease, senile dementia and related disorders (with attention to differential diagnosis and memory-enhancing agents).

—Causes, treatment, and prevention of depression in older persons (including investigations of the relationship of depression to suicide, alcoholism, medical disease, and other behavioral disorders)

—Psychoparmacology and polypharmacy.

—Behavioral medicine and the interface of physical illness and mental disorder in later life.

—Chronically mentally ill elderly.

—Treatment intervention, clinical trials, and service delivery models for the elderly.

—Effects of families, support systems, and self-help groups on the care of older persons with significant mental disorders.

—Prevention of pathology among elderly at risk for mental illness.

In August 1981, the National Institute of Mental Health issued a new announcement of its research programs. Interest in aging is evident throughout this announcement:

"NIMH research support programs are to increase knowledge and improve research methods on mental and behavioral disorders; to generate information regarding basic biological and behavioral processes underlying these disorders and the maintenance of mental health; and to improve mental health services. Research supported by the Institute may employ theoretical, laboratory, clinical, methodological, and field studies, any of which may involve clinical, subclinical, and normal subjects and populations of all age ranges, as well as animal models appropriate to the system being investigated and the state of the field. Areas eligible for support are—neurosciences, behavioral sciences, epidemiology, clinical assessment and etiological studies, treatment, prevention, and services research."

A list of research grants funded by the Center is included as appendix A of this report.

2. Research Training

National research service awards, including individual fellowships and institutional awards at the predoctoral or postdoctoral levels, provide support for the training of research scientists in the area of mental health and aging. Research training is just beginning as a Center program. As the research program of the Center gains strength and visibility, however, additional research training programs are likely to be initiated.

The current, agencywide announcement on research training programs (issued in August 1981) reflected a strong interest in aging.

3. Clinical/Services Training

The Center's program in mental health manpower development and training has focused on training efforts designed to improve mental health and related services to the aging within both the established mental health service delivery system (e.g., State mental hospitals, community mental health centers, etc.) and the mental health-related support systems (e.g., senior centers, long-term care facilities, etc.). Grants have been made available in three major categories—mental health services manpower education/training, mental health services manpower research and demonstration, and faculty development in geriatric mental health. In addition, the NIMH Division of Manpower and Training identified aging as a priority area in funding its training programs in the core mental health specialty disciplines (psychiatry, nursing, social work, psychology) and at the paraprofessional level. In fiscal year 1981, NIMH supported a total of 44 training programs, providing basic professional, graduate, postgraduate, and continuing education in mental health of the aging.

As part of the President's program for economic recovery, some programs are being proposed for phaseout. All mental health clinical training programs are included in this category and, consequently, are to be phased out by the end of fiscal year 1982. To implement this phaseout, the President proposed a rescission of the fiscal year 1981 budget. The rescission was to have eliminated all remaining funds for new and competing renewal awards as of March 10. Congress restored $2.9 million of these funds but specified that awards be restricted to competing renewals and be applied to certain targeted groups. Among these groups were disadvantaged and minority students, personnel in underserved areas, and specialists, including gerontological/geriatric mental health specialists, considered to be in critically short supply. In fiscal year 1981, no new awards were made for clinical training programs. The proposed faculty development award program, described in the NIMH 1980 Senate report, "Developments in Aging," was not implemented due to the prohibition against new grant awards in fiscal year 1981.

4. Nursing Home Improvement Program

Through its nursing home improvement program (NHIP), NIMH has addressed for several years the quality of long-term care. Following a Presidential support statement on nursing homes in August 1971, NIMH staff began to develop short-term mental health training programs for staff of the Nation's nursing homes. The programs were developed in appropriate educational institutions, professional organizations, and service agencies working under contract. This was the first time that nursing homes were the focus of a specific mental health training program. Because of limited resources, the immediate concern was to develop a program that could have maximum impact on as large a segment of the population as possible in a relatively short period of time. The program was intended to assure a sound basis for long-term planning. It was decided that the concern should not be as much with development of training materials or curricula as with the development of mechanisms for transmitting knowledge of principles and methods of practice which would promote the mental health of patients (and personnel) in nursing homes and minimize impairment of function caused by mental disorder. To achieve maximum efficiency and impact, it was necessary to use available resources rather than attempt to develop new ones. As a result, the program drew on existing organizations and established "models" of collaboration which could be tested, modified, and then put into operation throughout the country.

During 1980 the NHIP was placed within the Center for Studies of the Mental Health of the Aging. This provided an opportunity for closer coordination of research and training activities in the aging and nursing home programs. Regional NHIP staff members were closely involved in managing the grant to the American College of Nursing Home Administrators (ACNHA). ACNHA, in collaboration with the National Council of Community Mental Health Centers, developed cooperative programs between community mental health centers and nursing homes. These programs were based on a continuing education model and dealt with provision of mental health services, case consultation, inservice training of nursing home personnel, and program development. This project is national in scope. The training is being conducted on a regional basis during fiscal year 1981.

ACCOMPLISHMENTS

1. Cofunding With Various NIMH, PHS, HHS, and Other Federal Programs

Not all research in mental health and aging can or should be supported or administered by the Aging Center. In fields with strong and well-established technologies, such as psycopharmacology and epidemiology, specialized expertise already exists in other programs. Similarly, certain research issues are best conceptualized as life-course or adulthood issues in which the elderly represent only a part of the study. In these types of circumstances, the Aging Center has established mechanisms for joint funding. Projects have been cofunded with other components of NIMH; the National Institute on Aging; the National Institute of Neurological and Communicative Disorders and Stroke; the National Heart, Lung, and Blood Institute; the Administration on Aging; and the National Institute of Handicapped Research of the Department of Education. In this way the total aging effort of the institute is expanded and multiplied.

2. Interagency Collaboration

There are many Federal agencies with programmatic responsibility for the aged. Consequently, many mechanisms, both formal and informal, were established for coordination and joint program development. These mechanisms include: Long-Term Care Task Force; Information and Referral Work Group; Senile Dementia Initiative; Committee on the Retirement Age of Airline Pilots; Rural Services Task Force; and the Intergovernmental Science, Engineering, and Technology Advisory Panel.

Among the many specific examples of collaborative projects, two are especially notable. First, in the area of senile dementia, the NIMH Aging Center, together with two NIH institutes (the National Institute on Aging and the National Institute of Neurological and Communicative Disorders and Stroke), sponsored two international conferences on Alzheimer's disease/senile dementia. These conferences helped establish the state of the art in research, treatment, services, and policy related to this disease. Second, a regional training conference cosponsored by the Administration on Aging and the National Institute of Mental Health (NIMH) was held as the first formal step toward establishing local-level collaborative aging and mental health services. Two more such conferences will be held in fiscal year 1981.

3. Relationships with the National Institute on Aging (NIA)

The mandate given to NIMH by the Congress is to conduct a program of research, training, and services for the prevention and treatment of mental illness and for the maintenance and improvement of the mental health of the Nation. Since persons 65 years of age and older now constitute approximately 11 percent of the population and display the highest incidence of new cases and psychopathology, a significant portion of the NIMH effort should be directed toward the mental health problems and needs of this age group. The basic focus of NIMH efforts must be on mental health. The essential considerations are the manner in which aging affects mental health and the influence of mental health upon aging.

In this context, NIA's interest starts with the aging process itself, whereas NIMH's approach begins from the perspective of the mental health and illness of older people. NIA examines biomedical, social, and behavioral aspects of aging; NIMH studies adaptive and aberrant psychosocial functioning of the elderly and emphasizes etiology, prevention, treatment, and service delivery. The two Institutes also differ in a fundamental structural sense. NIA's focus is restricited to research and research training, while NIMH's Aging Center program encompasses services and clinical training in addition to research and research training efforts.

Since 1974, staff members of the NIMH Center for Studies of the Mental Health of the Aging have served on the Interagency Committee on Research in Aging. This committee is chaired by the Director of NIA. The committee, in conjunction with the National Advisory Council on Aging, helped define the research goals of the NIA and now meets regularly for purposes of coordination and consultation.

The staff of the Center, together with NIA staff, serve on the Interdepartmental Committee on Aging, which is advisory to the Commissioner on Aging and is functioning under the auspices of the Administration on Aging (AoA).

A considerable array of formal and informal relationships exists between the NIMH Center for Studies of the Mental Health of the Aging and the National Institute on Aging. Research applications of interest to both organizations are assigned to both for review. On occasion, dual projects which are approved but unfunded by the primary institute have been transferred for funding consideration to the secondary institute.

4. Publications

Results of research and training projects are usually published by the investigator in the technical literature of a field. In addition, the Center devotes considerable resources to the translation of research findings into materials for practice or training, and to the transmission of this information to interested individuals and groups. Materials aimed at the public and researchers are also developed by the Center.

FOOD AND DRUG ADMINISTRATION

Laws enforced by the Food and Drug Administration (FDA) are designed to protect the health, safety, and pocketbooks of all consumers regardless of age. This protection, however, is particularly important to the elderly consumer, and many of FDA's actions are of special interest to this age group.

PATIENT PACKAGE INSERTS

In April 1981, the implementation of a 3-year pilot program requiring patient package inserts for 10 drugs was stayed, to permit the agency to gather additional information about the cost and effectiveness of the planned program. Public hearings were held on September 30 and October 1, 1981, to solicit public comment for the reevaluation; additional written comments were accepted until October 15, 1981.

As of this date, no final decision has been made as to the status of the regulation published September 1980 nor of the draft guidelines for the 10 drugs to be studied in the pilot program. We expect a decision to be forthcoming in the very near future.

The FDA still encourages the testing of alternative methods of distributing written information to consumers and the use of voluntarily generated patient information as is currently being done by several drug manufacturers.

Several staff members of the agency are actively participating in the review of patient labeling prepared by the American Association of Retired Persons (AARP) for use by their prescription mail-in pharmacy service. Information about use of the drugs in the elderly is being supplied by outside medical and pharmacy consultants to the AARP. It is anticipated that the labeling will be in use in the very near future.

OTC (OVER-THE-COUNTER) DRUG REVIEW

In 1972, FDA established the OTC drug evaluation project to establish safety and efficacy standards in the form of monographs. The standards will insure that the drugs in the OTC marketplace are safe and effective for their labeled uses. The elderly will benefit from these standards as they will be able to make comparative cost decisions between brands of products with the assurance that all are safe and effective.

Seventeen advisory review panels were formed to assist in the review of 27 drug categories. All panels have completed their reviews. The review has grown from the original prediction of 27 drug categories to approximately 60 drug categories.

Final monographs have been published for the following drug categories—antacid, antiflatulent, daytime sedative, and sweet spirits of nitre. There are 28 proposals, 55 tentative finals, and 60 final monographs remaining to be published.

DRUG EXPERIMENTATION IN THE ELDERLY

In the past, comparatively less clinical research has been performed upon the elderly than other age groups. However, drug research for this segment of the population is extremely important because of the particular health needs of the aged, and because biological responses to drugs may not parallel those seen in other age groups.

In 1981, FDA strengthened existing regulations pertaining to informed consent and institutional review boards which govern the review and conduct of all human research involving FDA regulated products, regardless of whether the human subjects are institutionalized or are outpatients. IRB's are appointed by the institutions or facilities in which the research in conducted to assure that due consideration is given to local community interests. Their review of research protocols and informed consent processes must include the determination that adequate protection is afforded to all subjects particularly in the case of vulnerable groups in which category the elderly may often fall.

Each year FDA conducts approximately 400 inspections of IRB's to determine the adequacy of their procedures and informed consent reviews. FDA provides guidance and education to IRB's to assist them in carrying out their vital obligations to assure that the rights and welfare of all research subjects are adequately protected. Particular attention is given to assure that research subjects fully understand the implications of their participation in the research and to assure that their consents are freely given.

Additionally, routine audits are made of certain pivotal studies in pending NDA's and IND's. These may include studies conducted in elderly subjects, particularly the institutionalized elderly. These audits determine not only protection afforded the subjects but also integrity of data for which claims of safety and efficacy in elderly patients may be based.

DRUG EFFICACY STUDY IMPLEMENTATION (DESI) DRUGS

At the end of fiscal year 1981, the Bureau of Drugs had removed 897 prescription drug products which were initially approved for safety only through the new drug application (NDA) process from 1938 to 1962, and an additional number of related drug products, totaling 7,504 drug products removed. Reviews for these products concluded that they lacked substantial evidence of effectiveness. 2,184 drug products have been approved for safety and effectiveness of their claims.

This program will assure that consumers purchase only those drug products and their counterparts initially marketed from 1938 to 1962 which will effectively treat the conditions for which they are indicated. Because the elderly comprise approximately 11 percent of the population, but use approximately 28 percent of prescription drug products, this program will benefit them more than it does the general population.

THE MAXIMUM ALLOWABLE COST (MAC) PROGRAM

FDA is assisting the Departmentwide MAC program which is aimed at reducing health care costs through the increased use of lower cost generic drugs which are determined to be medically equivalent. FDA advises the MAC board of generic drug products which are medically equivalent to brand name products. The MAC program is conducted to prevent medicare and medicaid (tax-supported programs) from paying premium prices for brand name drugs when lower cost, medically equivalent generic versions are available. The MAC program adopts those products evaluated by FDA as medically equivalent. The elderly are benefited by having the assurance that the generic drugs they receive under medicaid programs are medically equivalent to brand name products.

PROFESSIONAL DRUG LABELING

The agency is giving increasing attention to the elderly in our programs which relate to the professional labeling of prescription drugs. We are increasingly aware of the effects of age on the metabolism, disposition, and adverse reactions, etc, of drugs. Under the labeling revision program, whereby drug labeling for products in the marketplace are being revised by manufacturers to meet regulations published in the Federal Register in June 1979, information pertinent to the elderly is being highlighted especially warnings, precautions, and dosage and administration. As the revision program progresses, we will have a good idea of the number and types of drugs in the marketplace that will be carrying specific messages for use of the drug in the elderly. This information will be incorporated into the class labeling for the particular drug group. The class label is intended to present information for individual drugs that are closely related in chemical structure, pharmacology, therapeutic activity, and adverse reactions in a manner that will permit comparison of the relative benefit-to-risk aspect of the drugs in the class.

OTHER PHS PROGRAMS

Several years ago, a liaison was formed between the Bureau of Drugs and the National Institute of Aging—National Institutes of Health. This effort is for document exchange, communications on drug research relating to the elderly and to provide expertise in the review of drug labeling information for geriatric use (modifications of dosage and for the addition of high priority warnings for this age group). Efforts will be increased as more information becomes available as to specific changes that are necessary for the elderly. Participation on the Ad Hoc Interagency Committee on Research on Aging and the National Advisory Council on Aging provides a direct link with the biological research, medical community, and consumer interests in the field of aging for the FDA. These efforts will continue to expand as the needs of this segment of the population grow.

MEDICAL X-RAY GUIDANCE AND EDUCATION EFFORTS STEPPED UP

Of the approximately 270 million medical X-ray examinations conducted in the United States annually, a substantial proportion are performed on elderly patients. It is generally acknowledged that a significant number of X-ray procedures may not be medically needed; factors which contribute to X-ray overuse include the patient's desire for reassurance, medical malpractice concerns on the part of physicians, and a lack of clear-cut criteria as to when certain X-ray procedures are indicated and when they are not.

FDA is seeking to address these problems with two programs, one addressed to physicians and the other to patients. To provide better guidance for physicians on the indications for certain X-ray examinations, the agency is convening expert panels of physicians to develop what it calls "X-ray referral criteria"—recommendations on which signs, symptoms, and/or patient history warrant the use of X-rays in a particular clinical circumstance. As they are developed, these recommendations are publicized to the medical community through professional journals, editorials, etc.

In a parallel program to educate consumers about medical X-rays, FDA is engaged in a nationwide public information campaign that, among other things, cautions consumers not to insist on X-rays, advises that they discuss with their doctors the need for an X-ray examination if one is being considered, and that they keep a record of previous examinations in an effort to avoid needless "repeats."

FRAUDULENT AND QUACK DEVICES

The Bureau of Medical Devices continues to support the House Select Committee on Aging in their investigation of medical and economic fraud that affects the elderly. Expert witnesses, data, publications, audiovisuals, and samples of fake and fraudulent devices are provided upon request.

The BMD's device quackery education program has been reissued for fiscal year 1982 and will be incorporated into an FDA-wide program sometime in fiscal year 1982. The BMD staff have participated in two audiovisuals on the subject of quackery in general, with special emphasis on medical device quackery, and these tapes were made available to CAO's implementing the education program in the field. Current examples of devices that make false and misleading claims include arthritis and pain relievers, figure enhancers, sex aids, hair growth and removal devices, and weight reducing devices.

The booklet entitled "The Big Quack Attack: Medical Devices" continues to be popular and is distributed free upon individual request. The booklet contains information on device fraud and informs consumers of the steps they should take to protect themselves from device quackery. Included in the booklet are the names of devices and device manufacturers that the FDA or the U.S. Postal Service have acted against for false and misleading claims in their respective labeling and advertisements.

HEARING AID DEVICES

An attachment to BMD's general medical devices consumer education program addresses the subject of hearing aids. Since, of the more than 15 million Americans suffering from hearing loss, approximately 5 million persons or more are 5 years of age or older, this education program affects the elderly. The objectives of the program are to: (1) Provide consumers with specific information on hearing aids so that they are better able to assume a primary role in maintaining proper hearing health care; (2) inform consumers about the existence of the 1977 FDA regulation on hearing aid professional and patient labeling and conditions for sale; and (3) gather consumer input on the concerns and/or problems consumers might experience with regard to the FDA regulation on the labeling and condition of sale of hearing aids. The focus of the program is on the requirements for dispensing a hearing aid device as stated in the regulation, promulgated after nearly 3 years of study and concentrated development. As an adjunct to this program, written materials are being distributed including the NBS/FDA booklet entitled "Facts About Hearing and Hearing Aids" and an FDA Consumer article entitled "Tuning In On Hearing Aids," both of which are free to individuals upon request. In addition, the BMD is developing a slide/sound show on the subject which is planned for completion in fiscal year 1982 and to be piloted by the National Retired Teachers Association/American Association of Retired Persons (NRTA/AARP). The pilot should reach approximately 15,000 elderly persons in NRTA/AARP's region I. The CAO's will also use the slide/sound show in conjunction with the consumer education program sponsored by BMD. With the completion of the slide/sound show, the hearing aid education/audiovisual package is completed.

INTRAOCULAR LENS INVESTIGATIONS

The clinical investigations by several sponsors of many models of intraocular lenses (IOL's) are being concluded and the data regarding the safety and effectiveness of these lenses are being assessed by the Bureau of Medical Devices and the ophthalmic device section of the ophthalmic; ear, nose, throat; and dental devices panel. This section is an advisory group composed of experts in ophthalmology and optometry. The investigations began in 1978 and the sponsors (IOL manufacturers) have collected data on approximately 500,000 patients who have had one of a few hundred different IOL's implanted since that time.

The assessment of the data submitted by several sponsors is progressing following the conclusion of a review of the general study by a group of biostatisticians. This group concluded that while there were problems with the general design, the data within individual applications could be assessed. The group also provided some general suggestions regarding the methods that could be used in the assessment.

In October 1981, the section recommended approval of lenses of three sponsors. Efforts are underway to complete work on these three applications.

On December 1, 1981, FDA granted its first approval of an intraocular lens—a plastic lens for surgical implantation after removal of the natural lens. This approval marks the first time FDA has determined that a particular brand and style of lens is safe and effective. The styles approved are chamber lenses which are implanted in the anterior chamber in front of the iris of the eye.

This approval is a major milestone in the clinical history of IOL's. It shows that the lenses can be an alternative to eyeglasses and contact lenses for some people whose natural lenses have been removed. The lenses can be particularly helpful to elderly persons who cannot see well with glasses alone and who have difficulty handling contact lenses. The approved lenses are labeled for use in persons 60 years of age or older, based on tests done with this age group.

Several PMA's are in various stages of assessment and additional PMA's are being submitted. The section and the FDA are committed to completing the assessments of these PMA's.

SODIUM LABELING INITIATIVES

As part of a five point program to lower the level of sodium in the American diet the agency will publish in early 1982, a proposal to amend current regulations to require sodium content information as part of nutrition labeling whenever nutrition labeling is required or is provided voluntarily. The agency is also seeking industry cooperation to lower the level of sodium in processed foods to the lowest extent possible.

As many as 60 million Americans may be potential victims of hypertension. Hypertension is especially prevalent and intensifies in the elderly. One part of the treatment for hypertension is the reduction in sodium intake. By encouraging manufacturers to lower the sodium content of processed foods and label foods with sodium content information consumers will find it easier to moderate sodium intake.

CHOLESTEROL CONTENT LABELING

FDA is currently reviewing a draft Federal Register proposal that would amend current regulations to require cholesterol and fatty acid content of foods to be included as part of nutrition labeling when claims about these substances are made. FDA expects this proposal to publish in the Federal Register in 1982. Most consumers, but especially the elderly are vulnerable to misleading claims about the value of particular foods in preventing or treating heart and artery disease. Cholesterol and fatty acid claims have the potential to be misleading in this regard. Nutrition information about cholesterol and fatty acid content on the food label would minimize the potential for deception and aid individuals on fat-modified diets.

TOTAL DIET STUDIES

FDA's revised total diet study program, which begins in February 1982, will involve the yearly collection and analyses of 234 foods from four locations of the United States. These 234 foods will be analyzed individually for 11 essential dietary minerals and over 120 chemical contaminants including industrial chemicals, heavy metals, and pesticide residues. The daily intake of these essential minerals and contaminants will be estimated for eight age-sex groups. Included among these eight groups are two which pertain to the elderly, 60 to 65 year old men and 60 to 65 year old women. Estimates of mineral and contaminant intakes are based on the usual caloric intakes and food preferences of these age-sex groups as determined from data of two national food consumption surveys (USDA's nationwide food consumption survey of 1977–78 and NCHS's national health and nutrition examination survey of 1976–80). The total diet study will thus allow yearly data as well as year-by-year trend data on the adequacy of dietary contaminants for the elderly.

FOOD FORTIFICATION POLICY

The FDA is initiating a review of the current food fortification policy to determine if modifications are appropriate. The primary focus is on basic staples. Particular attention is being given to meeting nutrient needs of the elderly as well as other particularly nutritionally vulnerable groups (e.g., infants, toddlers, older children, and women during the childbearing years). Much of the work involves detailed analysis of the data from the most recent health and nutrition examination survey (HANES 11). Particular attention will be devoted to iron, zinc, folic acid, and calcium. Current evidence suggests deficits of these nutrients in significant portions of the elderly population. To expedite HANES 11 data analysis, FDA has taken the initiative to organize an informal consortium from industry, academia, and sister Government agencies specifically involved in HANES 11 data analysis. The first meeting of this consortium is scheduled for November 30, 1981. Given the enormous amount of data to be interpreted, the primary purposes are to develop useful methods for processing the data, to minimize duplication of effort, and to establish communication mechanisms between the data users. A central point of concern will be meeting nutrient needs of the elderly in the presence of relatively low total food intakes.

FOOD SERVICE

The Bureau's Division of Retail Food Protection (DRFP) and the field's food service specialists furnish the Federal Administration on Aging (AoA), the State agencies on aging, and the providers of nutrition services to older Americans with:

—Uniform food protection criteria, including code interpretations.

—Expertise in identifying and solving problems associated with the preparation, handling, transportation, and serving of food for the elderly.

—Recommendations on mobile food-related equipment and practices.

—Training on food protection, through the workshop mechanism.

—Information on food borne illness outbreaks among older Americans.

Additionally, DRFP is currently assisting ADA in the establishment of a nationwide management training-and certification program. It is designed to assure that the people who provide food under ADA contracts, as well as area agency employees, are knowledgeable about food protection and the risk associated with food provision.

The above mentioned services are rendered to assist three ADA initiatives: Congregate meals (title III), meals-on-wheels (title III), and nutrition services for older Indians (title IV).

These programs cover over 1,100 nutrition service providers and nearly 12,000 congregate meal sites. About 600,000 meals are served daily to older Americans under ADA auspices, about 20 percent of which are home-delivered.

HEALTH RESOURCES ADMINISTRATION

Programs That Impact on the Elderly

The several missions of the Health Resources Administration include: to identify health care resource needs through a careful assessment of the health care system; to recommend changes to improve access to health care, improve continuity of health care, assure equal access to health education, and enhance the Federal, State, local, and private partnership; and, through program action, to improve both the health care system and individual health status. HRA focuses on a variety of program efforts that impact on the elderly, particularly through its Bureau of Health Professions and Bureau of Health Planning.

BUREAU OF HEALTH PROFESSIONS (BHPR)

The Bureau of Health Professions provides national leadership in coordinating, evaluating, and supporting the development and utilization of U.S. health personnel. It assesses the supply and requirements of the Nation's health professions and develops and administers programs to meet those requirements; collects and analyzes data and disseminates information on the characteristics and capacities of health professions production systems; and develops, tests, and demonstrates new and improved approaches to the development and utilization of health personnel within various patterns of health care delivery and financing systems.

The Bureau provides financial support to institutions and individuals for health education programs, administers Federal programs for targeted health personnel development and utilization, and provides technical assistance to national, State, and local agencies, organizations, and institutions for the development, production, utilization, and evaluation of health personnel.

Fiscal year 1981 program efforts directed toward the development of human resources needed to provide health care to the aged are summarized below for each of the four program divisions of the Bureau.

DIVISION OF MEDICINE

Grant program support under title VII of the Public Health Service Act included geriatric activities. Under section 781, 11 medical school awardees received a total of $353,354 for geratric medical training, impacting an estimated 8,039 individuals. The largest recipient was the University of Maryland which received $278,551 to continue its development of an area health education center (AHEC) program which includes graduate and undergraduate medical training in an urban geriatric setting. Six of the eleven awardees indicated they would be providing continuing education opportunities to health care providers within the AHEC service delivery area. Awards for continuing education activities ranged from $300 to $52,000 in fiscal year 1981.

Twenty-three grants ($347,370) were awarded under section 786(a) for graduate training in family medicine to support specific geriatric activities. Support for activities ranged from elective courses in geriatrics to salaries for geriatric consultants and instructors. Awards ranged from $7,732 to $86,000 for these activities.

Also under section 786(a), faculty development in family medicine, one medical school grantee indicated an intent to develop a geriatric center and two indicated they would hold discussion series for teaching faculty in family medicine on the treatment issues in geriatric health care delivery.

Additionally, in predoctoral training in family medicine (section 786(a)), 21 grantees indicated an intent to provide curriculum content in geriatrics and gerontology to undergraduate medical students. One of the grantees, Jefferson Medical College, received $6,500 to remunerate 10 geriatric preceptors.

A number of activities occurred under section 783 which had a direct or indirect impact on the elderly. Seven physician assistant programs indicated that students would be exposed to clinical medicine lectures, geriatiric health fairs and gerontological preceptorships as a part of their training. An additional three programs received a total of $7,650 to support geriatric courses and workshops.

Under section 780, a total of $14,113 was awarded to 13 department of family medicine grantees to strengthen the geriatric components in these administrative units. About 281 students are expected to be impacted by these awards.

The general internal medicine and general pediatrics residency program (section 784) had 30 grantees in fiscal year 1981 which indicated that residents would have exposure to the aged through electives and/or optional rotations.

DIVISION OF NURSING

Special emphasis was given in the Nurse Training Act of 1975 to the problems and health care of the aging. Grants and contracts were authorized for special projects to improve curricula in schools of nursing for geriatric courses and to assist in meeting the costs of developing short-term inservice training programs for nurses aides and nursing home orderlies. The latter programs emphasized the special problems of geriatric patients and included training for monitoring the well-being, feeding, and cleaning of nursing home patients, emergency procedures, drug properties and interactions, and fire safety techniques.

Under section 822 of the Public Health Service Act (PHS Act), nurse practitioner grants and contracts were authorized in fiscal year 1981 to educate nurses in the provision of primary health care to the elderly. The following active projects support nurse practitioner training programs which have as their major focus primary health care of the geriatric client, or have a distinct track for this purpose within a multiple-track project:

Applicant	Title	Fiscal year 1981 support
California State University, Long Beach, Calif.	Geriatric nurse practitioner program (master's degree).	$136,744
Hunter-Bellevue, City University of New York, N.Y.	do	228,576
Metropolitan State College, Denver, Colo	Adult/aging, family nurse practitioner program (BSN—completion program).	82,998
State University of New York, Buffalo, N.Y	Preparation of nurse practitioners in geriatric care (master's degree).	149,149
Hampton Institute, Hampton, Va	Graduate level geriatric nurse practitioner program (master's degree).	155,636
University of Colorado, Denver, Colo	Pediatric, family, adult/aging nurse practitioner program (certificate program).	391,404
University of Pittsburgh, Pittsburgh, Pa	Adult, family, geriatric nurse practitioner (certificate, master's option).	142,353
State University of New York, Upstate Medical Center, Syracuse, N.Y.	Pediatric, family, geriatric nurse practitioner (certificate program).	246,777
University of Miami, Coral Gables, Fla	Gerontological nurse practitioner (master's program).	139,001
Cornell University, New York Hospital, New York, N.Y.	Training program to prepare geriatric nurse practitioners (certificate program).	128,222
University of Wisconsin, Madison, Wis	Pediatric and geriatric nurse practitioner training (certificate, master's option).	227,157
Seton Hall University, South Orange, N.J	Gerontological nurse practitioner program (master's degree).	68,442
Columbia University, New York, N.Y	Development of leadership programs in primary care (pediatric, adult, geriatric) (master's degree).	218,488
University of Lowell, Lowell, Mass	Graduate program—gerontological nurse practitioner (master' sdegree).	147,697
Boston University, Boston, Mass	Nurse practitioner/clinician gerontological nursing program (master's degree).	149,999
University of Utah, Salt Lake City, Utah	Family, gerontological nurse practitioner program (master's level).	261,862
Total		2,874,505

Special project grants activities in 1981 under section 820 of the PHS Act have supported grants targeted toward curriculum revision, with a major focus on gerontological nursing, continuing and inservice education activities to upgrade and maintain competency and skills of practicing nursing personnel which include, but are not limited to, gerontological or geriatric content. A total of $544,250 was allocated in fiscal year 1981 to the following special project activities:

A. CURRICULUM REVISION GRANTS WITH A GERONTOLOGICAL/GERIATRICS FOCUS

Applicant	Title	Fiscal year 1981 support
Augustana College, Sioux Falls, S. Dak	Gerontological integration and practicum in nursing major	$39,262
Niagara University, Niagara, N.Y	Gerontological concepts in nursing practice	84,812
University of Tennessee, Memphis, Tenn	Primary care of the aged in the baccalaureate curriculum	77,752
University of Maryland, Baltimore, Md	Gerontology training program for nurse educators	38,350
University of Miami, Miami, Fla	Enhancement of a nursing curriculum to address health manpower needs.	63,720
Wilkes College, Wilkes-Barre, Pa	Expansion of geriatric component of curriculum	60,323
Total		364,219

B. CONTINUING EDUCATION GRANTS WHICH INCLUDE GERONTOLOGICAL NURSING CONTENT

Old Dominion University, Norfolk, Va	Continuing education for nurses in Virginia HSA–V	48,334
Hospital General de Castaner, Inc., Castaner, Puerto Rico.	Continuing education for nurses in rural areas	63,998
Michael J. Owens Technical College, Toledo, Ohio.	Program for continuing education for nurses	34,133
Total		146,465

C. INSERVICE EDUCATION WITH A GERONTOLOGICAL/GERIATRIC FOCUS TO UPGRADE SKILLS OF LICENSED PRACTICAL NURSES, NURSING ASSISTANTS, AND OTHER PARAPROFESSIONAL PERSONNEL

Westbrook College, Portland, Maine	Geriatric nurse assistant	33,566
Total		33,566

The following 19 advanced nurse training active projects under section 821 of the PHS Act provide support for the preparation of nurses in gerontological nursing at the graduate level:

Applicant	Title	Fiscal year 1981 support
San Jose State College, San Jose, Calif.	Gerontological nurse specialist program	$91,138
University of Kansas, Kansas City. Kans.	Training of gerontological clinical nurse specialists	116,829
University of California, San Francisco, San Francisco, Calif.	Graduate program in long-term/gerontological nursing	167,146
University of Pennsylvania, Philadelphia, Pa.	Gerontological nurse clinician	80,463
University of Michigan, Ann Arbor, Mich.	Ph. D. program in nursing	95,616
George Mason University, Fairfax, Va.	Master of science in nursing	71,314
Case Western Reserve University, Cleveland, Ohio.	Post baccalaureate program in gerontological nursing	119,671
Montana State University, Bozeman, Mont.	Nursing specialists for underserved rural areas	24,476
University of Maryland, Baltimore, Md.	Doctoral education for scholarly nursing leadership	30,758
University of Wisconsin, Milwaukee, Wis.	A program in community/gerontological nursing	35,381
Georgetown University, Washington, D.C.	Graduate nursing program	111,792
Syracuse University, Syracuse, N.Y.	Preparation for nursing of the rural aging	73,049
Murray State University, Murray, Ky.	Preparing rural clinician focus on aging and child	82,204
University of Rochester, Rochester, N.Y.	Gerontological nursing—major and minor emphasis	115,500
University of Oregon, Portland, Oreg.	Medical-surgical nursing—a gerontological focus	92,907
Duke University, Durham, N.C.	Advanced training for leadership in nursing	56,858
State University of New York, Binghamton, Binghamton, N.Y.	Master of science clinical nurse specialist program	149,055
Michigan State University, East Lansing, Mich.	Gerontological clinical nurse specialist	93,930
Total		1,608,087

Under authorization of section 301 of the Public Health Service Act, nursing research grants in fiscal year 1981 supported the following studies pertinent to aging:

Applicant	Title	Fiscal year 1981 support
University of California, Los Angeles, Calif.	Elderly women's evaluation of nurse practitioner's care	$36,103
George Mason University, Fairfax, Va.	Functional capacity of Hispanic elderly	97,792
University of Arizona, Tucson, Ariz.	Teaching caregivers—patient outcomes in nursing homes	26,185
University of Minnesota, Minneapolis, Minn.	Menopausal hot flash	74,109
University of Wisconsin, Madison, Wis.	Acute confusional states in elderly patients	109,475
University of Pennsylvania, Philadelphia, Pa.	Attributional analysis of chronic illness outcomes	34,137
COMPONENT STUDIES OF MULTIPLE—PROJECT RESEARCH GRANTS		
Ohio State University, Columbus, Ohio	Physical exercise—meno/postmenopausal symptoms	34,000
University of Arizona, Tucson, Ariz.	1. Nurse-client (elderly person) encounter in an ambulatory health care setting. 2. The nature and treatment of depression in noninstitutionalized elderly.	30,000
University of Wisconsin, Madison, Wis.	Patient self-disclosure in adults with specific chronic illnesses and in elderly persons living alone.	18,000
University of Utah, Salt Lake City, Utah	Social support, stress, and adaptation to forced residential relocation in an elderly population.	20,000
Wayne State University, Detroit, Mich.	1. Development of a social network instrument for the elderly. 2. Suicide among the aged—exploring the problem. 3. A nursing assessment of patients with Alzheimers disease.	40,500
Total		520,301

Under authority of section 472 of the Public Health Service Act as amended (42 U.S.C. 2891–1), national research service awards (NRSA) were made to five graduate nurses for support of their doctoral study in the field of gerontological nursing. The support totaled $40,200 ($5,040 student support, $3,000 institutional support).

Titles of the NRSA dissertations related to aging are: Staff care in chronic illness; aging and psychosocial factors affecting women's health; health care services: continuity of care, elderly; type A/type B behavior and retirement; and alteration of health behavior through education.

The division of nursing awarded two contracts in fiscal year 1981, related to aging. They are: Development, implementation, and evaluation of a nursing center (period of performance: May 28, 1981 to February 28, 1984)—$399,998. The development and implementation of a geriatric educational program for nurses (period of performance: June 24, 1981 to December 24, 1982)—$197,626. Total of two contracts—$597,624.

DIVISION OF DENTISTRY

The provision of adequately trained professional available to deliver primary dental care services to the geriatric patient is a major target area. Traditional delivery methods do not always provide access to dental care for many of these individuals both in terms of availability and costs. Under current authority, training support is available through general practice residency programs, which predominantly are sponsored by hospitals and provide comprehensive dental services to the elderly.

As part of an effort to promote further organized and coordinated education in geriatrics in dental schools, the division is supporting a project to evaluate current resources in geriatric dentistry education. The results of the evaluation will aid educational planners to determine the characteristics of geriatric dental curricula and their influences on students and dental practice. This will help dental educators to evaluate the strengths and weaknesses of their own programs, and improve their programs as necessary.

The division is also supporting a study of the characteristics of dental hygiene practice in nontraditional settings, such as nursing homes, hospitals, and day care centers for the elderly. The increased utilization of hygienists in this manner provides a promising approach to increasing oral health care for the elderly, as well as other special populations. To date, there are no systematic data regarding the extent and characteristics of these practices. This information will aid both the public and private sectors in determining appropriate, further implementation and desirable expansion of such dental hygienists roles. The data will also assist dental hygiene educators in developing curricula that prepare hygienists to provide services in nontraditional settings.

DIVISION OF ASSOCIATED HEALTH PROFESSIONS

Based on grants received the previous year, health professions schools continued projects designed to improve the knowledge skills, and practices of health professionals in assessing nutrition status in health and disease and advising and instructing patients about diet and nutrition. The grant program impacts on all types of patients, including the aged, and emphasizes interdisciplinary team training which must include medical students and at least two other professions which typically are dietitians/nutritionists, nurse/nurse practitioners and physician assistants.

A contract effort ($261,453) was completed with the ELM Institute for the development of a model training program for hospice staff. The focus of these five training manuals is on humanistic patient care and interdisciplinary team functioning in a hospice setting. The majority of patients in hospice settings are elderly.

A conference was held dealing with disease prevention and health promotion goals and objectives. One section of this activity, based on the Surgeon General's Report (Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention 1979), dealt directly with healthy older adults. Several other issues including high blood pressure control, nutrition, physical fitness and exercise, and accident prevention and injury control also relate to concerns of the elderly.

HEALTH PLANNING

Under the provisions of the National Health Planning and Resources Development Act, enacted in 1975, a network of State and local health planning agencies has been established throughout the country. At each agency, volunteer consumer and provider board members—more than 30,000 nationwide—work in a public forum to plan for area health needs, moderate health care costs, and improve the availability of health care services.

Although the health planning law contains no specific priority referring to planning for the health care needs of the elderly, there is a substantial amount of activity going on throughout the country based on agency identification of serious problems and local needs in this area. In an effort to learn what activities are being carried out by the State health planning and development gencies (SHPDA's) and health system agencies (HSA's), the Bureau of Health Planning surveyed State and local agencies in mid-1981. The study found that approximately 90 percent of the agencies had developed goals and objectives addressing the supply of skilled nursing and extended care facility (SNF/ECF) beds in their areas and the development of alternatives to institutional long-term care, in particular the establishment or expansion of home health care services.

Agencies reported a wide range of activities to insure the appropriate supply of SNF/ICF beds including project review, developing bed need assessment methodologies, and obtaining consumer involvement. Most agencies have been involved in efforts to increase the supply of SNF/ICF beds while many others were taking actions to either reduce or redistribuite nursing home beds. For example:

> The Western Colorado Health Systems Agency in Grand Junction helped prevent closure of the only nursing home in the six-county area surrounding Steamboat Springs. Because the agency's health systems plan had documented a need for long-term beds in the region, the agency took steps to save the nursing home when it became apparent it would close. This would have forced the relocation of patients to institutions over 200 miles away and left the area's 10,000 elderly residents without a long-term care facility. The agency, working with the State department of health, secured a 60-day extension of the closure order. This was intended to allow time for the community to find a buyer or raise funds for a direct purchase. Efforts of local groups were coordinated by the agency in an attempt to arrange financing. Because of the agency's action, the community was able to raise enough money ($250,000) to allow the local hospital to buy the facility, make needed renovations, and convert it from a profit to a nonprofit corporation.

Both HSA's and SHPDA's reported activities to increase alternatives to institutional long-term care services. Most efforts to increase home health care services involved activities in public education, building coalitions of consumers and providers to improve service delivery, and advocating changes in reimbursement policies for coverage of home health care services. The following example is typical of current agency activities in the area of home health services:

> The Agassiz Health Systems Agency in Grand Forks, N. Dak., has coordinated and assisted in several efforts leading to the development of home health programs in five counties—a goal identified in the health systems plan as a top priority. The agency held public meetings to inform citizens about the need and benefits of such services. Working with local government, health officials, providers, and community groups, the agency helped to arrange sponsoring agencies in each county. As a result, home health programs began operating in all five counties during 1980. Services are now offered in 16 of the 22 counties making up the health service area. The agency currently is working in four of the six remaining counties to start similar home health programs.

Besides working for the development of home health care services, planning agencies are involved in activities to develop other alternatives to institutional care. For example:

> The health systems agency in Flint, Mich., having identified in its health systems plan a local need for continuing day care to serve the elderly, helped establish a community day care center for senior citizens as an alternative to nursing home care. The agency helped secure a grant from a private foundation to plan for the center. Because of the action, the Center for Independent Living is now serving about 40 people each day. By providing a supervised living setting, many of the center's clients are able to live independently and not in a costly and restrictive institutional setting.
>
> Based on a State health plan priority, the New York State Health Planning Development Agency has worked to establish new alternatives to institutional care. The agency helped create an innovative "nursing home without walls" program which now provides aged and disabled persons with home health, support, and medical services. The agency also assisted in developing an "enriched housing program" in which elderly residents live together in small groups with support services provided. The services include housekeeping, meal preparation, shopping assistance, personal care and 24-hour emergency coverage.

HEALTH SERVICES ADMINISTRATION

I. INTRODUCTION

The Health Services Administration (HSA) continued its support for a variety of health care programs which were widely used by older Americans in fiscal year 1981. About 356,000 people 65 years of age or older were among the 4.8 million people treated in the 878 community health centers (CHC's) and 128 migrant health centers (MHC's) which were funded by the HSA's Bureau of Community Health Services (BCHS). In fiscal year 1981, the HSA's new Bureau of Health Personnel Development and Service placed 1,926 National Health Service Corps (NHSC) professionals in health manpower shortage areas. These NHSC professionals served nearly 1.3 million people which included 130,000 individuals 65 years of age or older. The HSA's Indian Health Service (IHS) continued to focus attention on the special health needs of older American Indians and Alaska Natives through interagency linkages and health care programs. Finally, the Bureau of Medical Services (BMS) delivered a broad range of inpatient and ambulatory health care services to older Americans through the nine Public Health Service (PHS) hospitals and freestanding outpatient clinics which were operating in fiscal year 1981. As described below, the health care programs and services offered by the HSA were used by older Americans who are among the medically underserved and statutorily defined beneficiary population groups served by the HSA.

II. HEALTH SERVICES ADMINISTRATION PROGRAMS

A. COMMUNITY HEALTH CENTERS

In fiscal year 1981, a total of 872 CHC's located in medically underserved areas provided a range of preventive, curative, and rehabilitative services to 4.2 million persons. About 7.7 percent of those served were age 65 or older. Formal and informal linkages existed between some center grantees, the U.S. Department of Agriculture (USDA), and the Administration on Aging (AoA) to augment the number of social and nutritional programs available. These include the food stamp program, the meals-on-wheels projects, and programs in which the CHC's provide service to seniors in congregate housing and sponsor multiphasic screening clinics in senior citizen centers and recreational areas. Other linkages include transportation arrangements with long-term care institutions and individual service arrangements with nonprofit senior centers and home health agencies. Special efforts have been made to integrate home health services into an overall health care package as evidenced by the certification of several CHC's as medicare home health providers.

B. MIGRANT HEALTH

The MHC program provides health care services for migrant and seasonal farmworkers and their families. Migrants live and work in predominantly rural areas where health resources are frequently scarce. The elderly migrant, beset by increasing health problems, is placed in a vulnerable position—faced with inadequate health resources and manpower, and language and cultural barriers. The MHC program authority, section 329 of the PHS Act, as amended November 1978, includes language that broadens eligibility to include a significant number of elderly and disabled. With that legislative authority, the MHC program can serve "individuals who have previously been agricultural workers but can no longer (be employed as migrant farmworkers) because of age or disability, and members of their families within the area it serves." In fiscal year 1981, services were provided to 581,000 migrant and seasonal farmworkers through 128 projects. Approximately 5.5 percent of those served were 65 or older.

C. HYPERTENSION

The hypertension program was established as a formula grant program providing funds for screening, detection, diagnosis, prevention, and referral for treatment of hypertension. In fiscal year 1981, the program continued to expand its focus on this condition which affects a significant proportion of the aging population. Key clinical indicators were used for assessing the effectiveness and quality of care in primary care centers. One of these requires that blood pressure measurements be done regularly on patients age 10 and over. The centers were held responsible for making sure that all patients with elevated blood pressure received followup services. It is estimated that screening services were provided to 9.3 million persons (among whom were a significant number of elderly).

D. HOME HEALTH

The home health services grant program, designed to increase the Nation's capacity to provide high quality home health services to the ill, aged, and disabled, completed its mission at the close of fiscal year 1980. Funds for the award of grants were rescinded from the budget and no grants were awarded in fiscal year 1981. During its operation, grants were made to initiate 85 agencies and to expant 260. As a result of these activities awards were made available in 175 counties where they were not previously available and availability and accessibility of services were greatly expanded in 550 counties. The home health services program was included in the Administration's preventive block grant program so that in States where there was need for additional home health services, such services could be developed in partnership with private and local resources.

E. THE INDIAN HEALTH SERVICE

The Indian health program provides health services to approximately 795,000 American Indians and Alaska Natives, many of whom reside on 250 reservations and Indian communities in 28 States and hundreds of villages in Alaska. It is estimated that 6 percent (48,000) of the American Indian and Alaska Native population is 65 and over. There is a preponderance of younger persons in the IHS population; the Indian and Alaska Native median age is 18.4 which is lower than the median age of 28.1 of all races in the United States. However, attention is being focused on the needs of the elderly primarily as a consequence of both the 1978 Indian Conference on Health of the Elderly conducted by the National Indian Council on Aging and titles III and VI of the Older Americans Act.

Specific services and interagency linkages have been geared to serve the special health needs of the elderly. Services offered in conjunction with the AoA include congregate meals, meals-on-wheels, minor home repair, shopping assistance, transportation, health surveillance, outreach, part-time employment, and inservice training for titles III and VI personnel. Other linkages include the IHS medical and social service surveillance for nursing home and extended medical care patients, and assistance in obtaining services under medicare, medicaid, the USDA-administered food assistance program, Veterans Administration, and other Federal and State programs.

F. THE NATIONAL HEALTH SERVICE CORPS

The mission of the NHSC is to provide health manpower to American communities and population groups whose health needs are not otherwise fully met. The NHSC places physicians, dentists, nurse practitioners, and other health professionals in areas that have health manpower shortages. One of the factors used to designate these areas is the percentage of the population that is 65 or older. Since older people usually have special health needs and reduced mobility, the presence of health personnel in their communities is especially important. The Corps works closely with the CHC and MHC programs and provides assistance in recruiting health manpower for these programs.

In fiscal year 1981, the NHSC affirmed its commitment of health care to the elderly by maintaining its provider and budget expenditure levels for geriatric care. The Corps focused on geriatric medicine and other gerontological issues at the NHSC regional inservice conferences for providers and emphasized geriatric health concepts. Through various programs in communities, Corps assignees reach the elderly with programs such as nutrition counseling, high blood pressure screenings, physical therapy, and stroke prevention.

G. PUBLIC HEALTH SERVICE HOSPITAL CARE

A broad range of both inpatient and outpatient care was offered through the nine PHS hospitals (eight general medical-surgical (GMS) and one specialty hospital for the treatment of Hansen's Disease) and 27 freestanding outpatient clinics operated by the BMS. The 8 GMS hospitals and 27 freestanding outpatient clinics, which were closed at the end of this past fiscal year, were utilized by a variety of congressionally defined beneficiary groups including seafarers, military, and Coast Guard personnel and military dependents. Nearly 20 percent

(5,416) of the total PHS hospital discharges (27,637) recorded by the end of the third quarter of fiscal year 1981 was attributed to beneficiary individuals 65 years of age or older. The hospital at the National Hansen's Disease Center also reported that all of their 150 long-term residents of the center were over 60 years of age.

III. THE HEALTH SERVICES ADMINISTRATION/ADMINISTRATION ON AGING DEMONSTRATION PROGRAM

The HSA completed its interagency agreement with the AoA at the close of fiscal year 1981. The HSA provided support for special demonstration projects through the CHCs program, the PHS hospital program and the IHS.

A. COMMUNITY HEALTH CENTERS

Three CHC's served as model projects under the joint HSA/AoA demonstration initiative to provide information as to how its primary care centers may better serve the elderly and the chronically impaired older person. The projects were designed to identify the components of a program necessary to provide services adequate to meet the plan of care for each individual in the target population. Such components included outreach to potential recipients of services, health education and screening, nutrition education and counseling, treatment (preventive, diagnostic, and therapeutic), home care, and transportation. Each project was required to provide such services either directly or through linkages with the area agency and community providers.

One such project was the San Ysidro CHC demonstration in the South Bay area of San Diego. This project was concerned, in particular, with providing community outreach and health education services for a target population largely of Hispanic elderly who often do not use the health care services available to them as a consequence of real and perceived cultural barriers. A multidisciplinary team comprised of health educators, physicians, social workers, community health assistants, and health aides bring a full range of coordinated health and social services to the elderly in that area.

Linkages have been established with the three senior citizen centers and two nutrition centers in order to introduce and engage the elderly in the area into the service network.

The Providence Ambulatory Health Care Foundation, which maintains seven CHCs in Providence and a geriatric health care clinic, set out to improve the health care for the elderly population living in designated census tracts by establishing linkages with other elderly serving agencies such as the Visiting Nurse Association of Providence, the Rhode Island Department of Elderly Affairs, the Providence Mental Health Center, Project Hope, and the Volunteers Intervening for Equity. Participating agencies cooperate through establishment of reimbursement agreements, utilization of common referral forms, placement of all service information on the applicant agency's case record, and the monitoring of all care or services provided by the case manager from the applicant agency.

The Neighborhood Health Center, Inc., St. Louis, Mo., has developed a neighborhood-based case management system to provide outreach, assessment plan of care, linkages, moniotring, advocacy, and evaluation/reassessment to frail and semifrail elderly. It links and interfaces a variety of health related services into a continuum of care network. Thus, 75 percent of the elderly in select neighborhoods can be identified and contacted. A continuum of services are being developed through the reconfirming of existing and establishment of new interagency linkages. Individualized service plans are implemented for about 250 at-risk elderly neighbors. Gaps in services can be identified and solutions investigated.

B. PHS HOSPITALS AND CLINICS

The BMS projects involved the funding of demonstration projects which focused on the elderly residing in the immediate geographic area served by three PHS hospitals. The demonstration projects share the common goals of improving availability and the accessibility of services for the chronically impaired and frail adult.

The PHS hospital in Baltimore, Md., established a geriatric health service that provided a comprehensive set of medical-psychological services for a defined population of elderly persons. The project developed several points of entry into the system by locating in existing community organizations, such as the Action in Maturity and the Northwest Senior Centers; developed a network of service provider points such as hospitals, CHC's, and private practitioners; developed an integrated system of referrals to already existing psychosocial services; and arranged for the transportation and tracking of elderly clients through the system. The staffing of the geriatric health unit consisted of a full-time nurse practitioner, social worker, secretary, and part-time health educator and physician.

The goal was to maintain and/or improve the functional ability of noninstitutionalized residents of Baltimore over the age of 60 through:

—Detection of disease and psychosocial problems in the elderly;

—Provision of limited primary health and social services.

—Providing a referral mechanism for appropriate medical treatment and psychosocial assistance; and

—Conduction of health education programs.

This project concentrated on meeting the health and psychological needs identified by community surveys in the Hampden-Woodberry-Remington area, the needs assessment of the area agency on aging and those problems identified by case management at the participating senior centers.

The PHS hospital in Boston, Mass., is located in the Allston-Brighton area which has a population of approximately 12,000 elderly aged 60 and over. Although social services are available for the elderly in the area, certain social needs continue to be identified, such as transportation, some housekeeping, and crime protection. Further, the supply of primary care in the area is inadequate. Between 1,000 and 2,000 elderly have reported problems with health status. Five percent of Allston-Brighton elderly are homebound. In 1978, a survey conducted by the Boston Commission on Affairs of the Elderly reported that about 17 percent or 2,000 of the population 60 years and older living in the Allston-Brighton area had no contact with a physician during that year. Further, half of the eight census tracts are identified as either medically underserved areas or health manpower shortage areas. The PHS intends to mobilize its resources in order to help alleviate problems of availability and accessibility of primary care. To carry out this purpose, the PHS developed a primary care program aimed specifically at the elderly in Allston-Brighton. It utilized physicians, nurse practitioners, case aides, and other specialty services in order to provide health treatment, education, nutrition counseling, health detection, and other services. In order to provide a comprehensive package of services to the elderly, the PHS developed model linkages to the social services/health care system. The PHS offered its services regimen at the hospital ambulatory unit, at the home site, through mobile clinics in the community, and at the PHS nutrition program currently in operation.

The AoA funds were requested jointly by the PHS hospital in Seattle, Wash., and the central Seattle CHC, a BCHS grantee, to link primary care services with senior center activities, home health care, and chore services. Medical backup for outpatient, inpatient, and rehabilitative services was included. Participating agencies are the PHS hospital, Pike Market Community Clinic, Market Senior Center, neighborhood health centers, Seattle-King County Health Department, Visiting Nurse Service, Harborview Medical Center, Virginia Mason Hospital, Homemakers Upjohn, and Seattle-King County Division on Aging.

There was a phased approach focusing on downtown Seattle in fiscal year 1981, developing additional projects in south Seattle in years two and three. The overall goals were to create a citywide system of coordinated elderly services helping older adults remain independent active members of their communities with decreased reliance on high-cost health care. Project objectives include—the development of a well-coordinated package of health and social services emphasizing independence, self-esteem, and dignity; and the improvement of coordination between health and human service agencies serving the elderly by maximizing the use of home health services to replace short- or long-term care. To accomplish these objectives, the AoA funds supported a nurse practitioner, outreach worker, social service advocate, public health nurse, health aide, and patient advocate. These individuals provided primary geriatric health care; outreach services, including casefinding, patient education, referrals; patient advocacy for legal, housing, employment, food, and other social services; health screening; home visits; footcare; and patient advocacy in hospital settings. Project coordination in fiscal year 1981 was the responsibility of the Pike Market Community Clinic, a member of the central Seattle consortium.

C. INDIAN TRIBAL ORGANIZATIONS

The Yakima Indian Nation, in conjunction with the IHS and its area agency on aging, propose to supplement preventive health care, develop coordination methods for social and health services to the Indian elderly, and establish a certified in-home health program on the Yakima Indian Reservation. Professionals in the program, or through other coordinating offices, work with the client and his family to develop an individual care plan promoting a maximum level of health and activity independence. The demonstration projects provides for a community health nurse, part-time licensed physical therapist, three homemakers, and three home health aides. These staff members work solely for the Indian elderly, age 60 years and over. In fiscal year 1981, the Yakima Nation in-home health care program continued to coordinate its geriatric health program with the IHS, Toppenish, Wash. This grant was awarded in the amount of $80,000 for fiscal year 1981.

The geriatric health program, developed by the Cherokee Nation, provided preventive health care services to Cherokee elders by the establishment of programmatic linkages with existing health care and human services agencies in the Cherokee Nation, the provision of extensive community and individual counseling, increased involvement of the Cherokee elder in community activities, and an emphasis on preventing and promptly treating illness. The geriatric health program plan for fiscal year 1981 was changed to reflect the need for more assistance in health matters through the addition of nursing staff and the formation of a home health agency. The staff of the geriatric health program, which consists of a director, two bilingual geriatric specialists, two elderly health aides, and one licensed practical nurse, coordinate the efforts to improve the health status of the Indian elder in the Cherokee Nation. This grant was awarded in the amount of $96,637 for fiscal year 1981.

The intent of the Navajo Nation project is to demonstrate the use of geriatric nurse specialists to increase the access of high-risk elderly to primary health-related services in the Navajo Nation. The principal aims of the project are: To assist in the identification of Navajo elderly at risk of being institutionalized; to increase the access of this group to health care of all types; and assess and eventually improve existing systems of referral, followup, and case coordination. Involved in this demonstration project was the Department of the Divisions of Health Improvement Services and Social Welfare, the community health nursing program and various agencies within the Office of Direct Care Services of the Navajo area. The IHS was involved, as was the Navajo Area Bureau of Indian Affairs Branch of Social Services. Finally, involvement also extended to programs of the Office of Navajo Economic Opportunity, such as those funded by ACTION and title V of the Older Americans Act. This grant was awarded in the amount of $84,096 for fiscal year 1981.

IV. CASE PROFILES—DOCUMENTATION

Over the long run, collaborative efforts between the AoA and the HSA will build on the demonstration projects and evaluation findings with the goal being to develop methods of linking AoA/HSA resources with other health care and social services resources so as to insure the availability and accessibility of comprehensive health care to the unserved and underserved elderly. Through the implementation of these projects, the AoA and the HSA aimed to foster the development, testing, and adoption of models which would improve the existing system of health and social services and enhance the well-being of socially and economically deprived older persons. Each funded project should be the forerunner which other agencies and organizations can adopt or adapt to their use. Projects are expected to incorporate the best of current knowledge and practice by demonstrating more effective, more acceptable, more efficient, and more economical ways of serving older persons.

A two-volume study (contract No. HSA 240-80-0016) on the 11 demonstration projects was completed in fiscal year 1981. The study, conducted by an outside contractor, identifies, describes, and compares the methods and approaches used in delivering health and social services to the unserved and underserved elderly at the 11 demonstration sites. The study not only contains complete profile descriptions on the demonstration projects, including major social, demographic, and project characteristics, but also details how each project addresses program requirements imposed upon the HSA/AoA grantees.

NATIONAL INSTITUTES OF HEALTH

NATIONAL INSTITUTE ON AGING

INTRODUCTION

In 1981, the National Institute on Aging (NIA) continued its exploration of a wide range of medical and psychosocial issues affecting the Nation's growing older population. The conclusion of much of the research supported and conducted by the Institute is that disease and disability, not aging, take the greatest toll on heatlh in later life. For example, findings described in this report indicate that aging does not impair the heart muscle, intelligence can sometimes improve with age, and certain immune processes may compensate for age-related declines elsewhere in the immune system.

Many scientists are now investigating how aging processes and a variety of other factors increase susceptibility to the diseases and disabilities that cause illness and dependence among the elderly. The research programs of the NIA span a wide range of disciplines, from cell to society. The results of this research should contribute to a healthier, more independent, and more productive old age.

PROGRAM HIGHLIGHTS

In addition to its research programs, the NIA is involved in a number of special initiatives. These range from a study of the medical aspects of mandatory retirement of airline pilots to efforts to establish teaching nursing homes similar to the teaching hospitals affiliated with many medical schools.

Highlights of new NIA projects, conferences, and program initiatives include the following:

TEACHING NURSING HOME

In April 1981 the NIA proposed the creation of teaching nursing homes to help the Nation gear its biomedical and other research and training capacities to the long-term care needs of its elderly population. The NIA recommended that the public and private sectors form a partnership to develop teaching nursing homes in affiliation with universities, especially their medical, nursing, and social service schools.

The Nation's expenditures for nursing homes are nearing $22 billion a year and probably will quadruple by 1990. These high costs are in part the reflection of a lack of knowledge about effective and cost-saving methods of prevention, diagnosis, and treatment regimens to bring older people back to health.

The teaching nursing home would focus on such research topics as senile dementia, fecal and urinary incontinence, gait disorders, management of bedsores and pain, nutritional problems in healing and rehabilitation, behavioral and organizational interventions designed to improve patient functioning, and drug interactions. In addition to conducting research, the model facility would be a place for training professionals for careers in research and service. Doctors, nurses, pharmacists, behavioral scientists, social workers, nurse aides, and physical, occupational, and speech therapists would have opportunities to work and learn collaboratively.

In November 1981, the Institute published a program announcement on the establishment of teaching nursing homes in conjunction with university medical schools or medical centers. The first awards are scheduled to be made in September 1982.

AIRLINE PILOTS STUDY

In 1979 Congress mandated a study of the effects of aging on airline pilot health and performance as a means of determining if mandatory retirement at age 60 is medically warranted. The Experienced Pilots Act requested that the National Institutes of Health (NIH), in conjunction with the Department of Transportation, undertake a study of the "age 60 rule" and the adequacy of medical certification procedures and examinations for commercial and airline transport pilots and submit a report of its findings to Congress. The NIA was the lead NIH component in this activity.

The NIA contracted with the Institute of Medicine (IOM) of the National Academy of Sciences to obtain an objective review, summary, and assessment of existing scientific knowledge relevant to the questions posed in the legislation. A panel of experts was then formed to examine the IOM report, review public comments, and assist the NIH in preparing its response to Congress.

The report was sent to Congress on October 2, 1981. Citing the absence of medical appraisal systems that can predict individual pilot health and performance, the panel recommended that the present age limit be retained. However, it proposed an approach that requires a program of medical and performance appraisal that could be applied on an individual basis to permit some pilots to continue flying to age 65.

The panel concluded that there is "no special medical significance to age 60"—or to any other specific age—for mandatory retirement of airline pilots. Yet it found that "age-related changes in health and performance influence adversely the ability of increasing numbers of individuals to perform as pilots with the highest level of safety."

The panel recommended "that the Federal Aviation Administration or some other appropriate Federal agency be requested to engage in a systematic program to collect the medical and performance data necessary to consider relaxation of the current age 60 rule."

It also recommended "that, in view of the growing importance of commuter air carriers, the present age limit be extended to cover all pilots engaged in carrying passengers for hire" in order to provide a level of safety equivalent to that of commercial air carrier operations.

WHITE HOUSE CONFERENCE ON AGING

The NIA assisted in the planning and operation of the White House Conference on Aging, which was held from November 29 to December 3, 1981. In addition, the Institute commissioned 36 scientific papers on various health topics for the conference, and NIA staff members prepared lay summaries of a number of these papers for distribution to conference delegates. The NIA displaced its own exhibit at the conference and helped coordinate an NIH-wide Health-Research Fair.

The NIA also prepared two progress reports—one on senile dementia of the Alzheimer's type (SDAT) and the other on geriatric medicine—as well as two Medicine?" for distribution at the conference.
shorter brochures entitled "What Is Aging Research?" and "What Is Geriatric

A series of mini-White House Conferences were held prior to the November meeting, three of which—on oral health care, impaired hearing, and low vision—were supported by the NIA. Along with the National Institute of Neurological and Communicative Disorders and Stroke, the National Institute of Mental Health, and the Alzheimer's Disease and Related Disorders Association, the NIA also sponsored a mini-conference on Alzheimer's disease and related disorders. This meeting explored biochemical and pharmacological issues, risk factors, and social and psychological aspects of Alzheimer's disease.

TRAINING PROGRAM DEVELOPMENTS

Among the programs that the NIA has initiated to encourage scientists to pursue aging research are the Geriatric Medicine Academic Award, the Geriatric Dentistry Academic Award, and the NIA Academic Award Program. The first award is designed to stimulate faculty and curriculum development in geriatrics at medical schools and other institutions; the second is intended to foster curriculum development and to encourage research and careers in geriatric dentistry; and the third aids in recruiting and preparing future academic investigators for careers in research and teaching with special emphasis on geriatric medicine and related clinical disciplines.

Established in 1978, the Geriatric Medicine Academic Award program is well underway and 22 grants have been made. A second annual meeting of the awardees was held on June 29–30, 1981 in Bethesda, Maryland. It provided a useful forum for the grantees to discuss their accomplishments and recent program developments at their respective medical schools. The meeting highlighted the development of a model geriatric curriculum in medical school undergraduate primary care education. It also included a report from the Veterans Administration on the use of a urinary incontinence teaching module suitable for undergraduate medical student instruction. Members of the NIA staff introduced the new Teaching Nursing Home Award.

The Geriatric Dentistry Academic Award program was started in 1979 in cooperation with the National Institute of Dental Research. Six awards have been made and the projects are now fully operational.

The biomedical community has enthusiastically endorsed the new NIA Academic Award Program, introduced this year. Professionals in the field view it as a valuable adjunct to academic development in the Nation's medical schools. Applications are being received and the first awards will be made early in 1982.

WORKSHOPS AND CONFERENCES

WORKSHOP ON URINARY INCONTINENCE

In November 1980, the NIA brought together a small group of medical specialists and private sector representatives to discuss urinary incontinence in the elderly. The purpose of the workshop was to define the incidence, causes, diagnosis, and treatments of this widespread problem, and to make recommendations for future studies.

Incontinence is not a disease, but a physical sign of an underlying medical or psychological problem. In this country, urinary incontinence is both underdiagnosed and undertreated, and is largely a "hidden" condition. Too often, health care providers (family members, nurses, or other nursing home personnel) view urinary incontinence as an unpleasant and demanding sanitation problem, while among the sufferers themselves the overriding emotional responses are frustration, embarrassment, and fear.

Among the elderly, urinary incontinence is one of the most common causes for admission to hospitals. In addition, up to 50 percent of those in skilled nursing homes probably suffer from some degree of urinary incontinence.

The workshop generated a sense of the priorities in research on incontinence, giving those present a better sense of what types of studies are feasible and desirable. Also emphasized was the need to promote better research on the association of incontinence with specific diseases and the degree of incontinence that cannot be traced to any specific disease process.

A technical paper based on the proceedings of this workshop has been prepared and will be submitted for publication this year.

NONLETHAL BIOLOGICAL MARKERS OF PHYSIOLOGICAL AGING

As a first step toward assessing interventions—dietary, exercise, and other manipulations—that might alter the rate of human aging, the NIA held a conference in June 1981 to evaluate the biological markers of aging. "Biomarkers" of aging are those physical and behavioral changes occurring at predictable times during the aging process. If a specific intervention proves to delay the onset or progression of a biomarker, that manipulation may be a potential tool for extending the healthy years of life.

Thus far, dietary restriction is the only intervention which repeatedly alters the rate of aging in mammals. Other methods of intervention have been tested, including exercise and manipulations of the immune system.

Conferees discussed more than 20 possible biomarkers in animals and humans. In rats, one reliable marker is the tail tendon, which shows specific biological alterations that correlate with the animal's age. Certain age-related changes in the cardiovascular system, such as left ventricular hypertrophy (an enlargement of the left side of the heart), are also seen with regularity in rats. Other examples are a measurable decline in immune function correlating with the animal's age and a loss of memory function as evidenced by passive shock avoidance trials.

In humans, some predictable aging markers include specific hearing, vision, and cardiovascular changes; bone loss; sleep variations; and alterations in glucose tolerance and immune function. A marker which could be especially useful in human studies is forced vital capacity, a measurement of lung capacity and chest wall musculature. Senile miosis, a reduction in pupil size with increasing age, appears to be another reliable marker in humans.

These and other markers discussed at the conference were found to be good indicators of aging, as well as practical for use in intervention studies. Conference proceedings will soon be published.

INTERNATIONAL DEVELOPMENTS IN AGING

In conjunction with its regular meeting in May 1981, the National Advisory Council on Aging held a symposium on International Developments in Aging. Included for discussion were the designation of the NIA as a World Health Organization Collaborating Centre for Joint Cooperation on Research on the Care of the Aged, and the 1982 United Nations World Assembly on Aging. The purpose of the symposium was to inform participants of the activities in aging currently being conducted throughout the world.

PLANNING WORKSHOP ON THE NEUROCHEMISTRY OF ALZHEIMER'S DISEASE

At this NIA workshop held in August 1981, government scientists and representatives from several leading research institutions discussed a wide range of issues including: the causes and development of Alzheimer's disease; brain chemistry; the effect of drugs on the brain; diagnosis; and scientific and organizational issues influencing research on Alzheimer's disease.

PERSPECTIVES ON PREVENTION AND TREATMENT OF CANCER IN THE ELDERLY

The second in a series of working conferences on aging and cancer was held in September 1981. It was jointly sponsored by the NIA and the National Cancer Institute. Among the topics discussed were: the physiological and surgical considerations in caring for the elderly cancer patient; site-specific treatment perspectives (breast, colorectal, prostate, and skin cancer); psychosocial factors in cancer over the life course; and screening, early detection, and diagnosis. A major conference goal was the recommendation of research efforts in selected areas where knowledge is unavailable or ambiguous, and intervention techniques which merit additional exploration and development.

RESEARCH ADVANCES

CELL BIOLOGY STUDIES HAVE MANY APPLICATIONS

To learn more about age-related changes in patterns of cell growth, development, and function, new techniques have been developed to study human cells in the laboratory. Richard Ham at the University of Colorado in Boulder, for example, has developed methods to obtain relatively pure populations of human epidermal keratinocytes (cells in the outer layer of the skin that synthesize the protein keratin), to store these cells for use in a series of experiments, and to cause the keratinocyte population to differentiate (develop specialized functions) at will. Studies conducted with these cells should contribute to our understanding of how cellular growth and specialization are regulated. Such information might ultimately lead to ways of preventing or curing cancer and degenerative changes associated with aging.

In another NIA-supported project, James R. Smith and Peter DelVecchio at the W. Alton Jones Cell Science Center in Lake Placid used cultures of cells that line the pulmonary (lung) arteries of oxen to study an enzyme that is important in stabilizing blood pressure. They have found that as these cells age in culture, there is a considerable decrease in the activity of the angiotensin converting enzyme. This enzyme both activates angiotensin, a substance which stimulates contraction of the capillaries and arteries, and inactivates bradykinin, which lowers the blood pressure. Therefore, the angiotensin converting enzyme plays a major role in blood pressure regulation. The knowledge that this enzyme is less active in aging cells may be useful in future studies of blood pressure problems in the elderly.

GENETIC STUDIES PROVIDE CLUES TO AGING

Before we can fully understand why organisms grow old and die, further knowledge of the relationship of genetics to aging and longevity is needed. Studies conducted and funded by the NIA use a variety of systems, from cells to human populations, to investigate the genetic bases of aging and longevity.

One way to examine the molecular, cellular and genetic aspects of human aging is to analyze human chromosomal disorders that result in premature aging, such as Down's and Werner's syndromes. Recent research funded by the NIA has firmly established that Werner's syndrome is a chromosomal instability disorder. George Martin and Darrell Salk at the University of Washington have demonstrated characteristic "hot spots" of such instability within the cellular DNA. Another study, by W. Ted Brown at the New York State Institute for Basic Research in

Mental Retardation, is seeking to identify proteins that are coded for by chromosome 21 and are expressed in excess amounts in Down's syndrome, a disorder caused by an abnormality in chromosome 21. Brown has identified five proteins coded for by chromosome 21, including the enzyme superoxide dismutase, which is expressed in excess in Down's syndrome cells.

Fundamental knowledge about the events leading to aging in animals such as primates, rodents, roundworms, and fruit flies helps to formulate theories and guide experiments in human aging. In studies using animals, it is important that aging be measured by a variety of parameters (characteristic elements) that change with age, rather than by the sole criterion of lifespan. Richard Russell at the University of Pittsburgh has been developing an index of age-dependent parameters for *C. elegans*, a parasitic roundworm. He has identified both nondestructive parameters, such as movement and defacation frequencies, and destructive parameters, such as an increase in three lysosomal enzymes, which indicates cell damage. Such a complex index of aging is needed to determine whether experimental treatments or genetic alterations that affect lifespan change the aging process or simply accelerate or postpone mortality by affecting some specific disease state.

Ronald Konopka at the California Institute of Technology has been studying the effect of altered daily rhythms on longevity in *Drosophila* (fruit flies). He has found that the longetvity of several strains of *Drosophila* is not altered when they are subjected to environmental light cycles with periods greatly different from their genetically determined rhythms. However, a mutant that has irregular rhythms has a strikingly increased longevity under all the environmental conditions tested. Konopka's research is yielding information about the interaction between genetically determined rhythms and environmental ones, and the effects these cycles have on longevity.

Behavior Genetics.—Behavior genetics is emerging as an important aspect of the NIA's behavioral sciences research program. Studies in this field are of value because they address the degree to which genetic factors predispose the individual to specific behavioral patterns in later life, and because they investigate the relationship of inherited diseases to changes in behavior with aging (for example, the role of genetic factors in SDAT). These studies also have high potential for increasing our understanding of the relative contributions of heredity and environment to the aging process.

In one study that has behavioral genetic aspects, David Wolfe at the University of Kentucky is examining long-term, in-depth genealogical and historical information about the Scots-Irish of northeastern Kentucky. Although analysis of the data is just beginning, some interesting information has emerged. Two goals of the Wolfe study are to characterize the Scots-Irish gene pool and to collect data that will permit an estimate of the degree to which longevity can be inherited. Toward these ends, biochemical data for 317 individuals have been collected. Comparative biochemical data for 320 documented long-lived individuals from Soviet Georgia (Abkhasians) have been partially analyzed. It appears that, as initially hypothesized, individuals who live longer have unusual blood serum and red cell surface proteins which, in conjunction with trace elements, result in increased oxygen transport and metabolic efficiency. This findings suggests a direct link between the genetics of longevity and nutrients in the culturally determined diet.

RESEARCH FINDS EVIDENCE OF GROWTH IN THE AGING BRAIN

Traditionally, the process of aging in the cerebral cortex (the outer layer of the brain) has been viewed as a relentless deterioration. Several scientific studies have shown that there is a loss of neurons (nerve cells) with age as well as degenerative changes in the dendrites of nerve cells. Dendrites are the branchlike extensions of the cell body through which it receives virtually all messages which come from cells in other parts of the body.

At the University of Rochester, NIA grantee Paul Coleman and his colleagues recently questioned previous studies with their finding that, in the absence of disease, dendrites in at least part of the cortex continue to grow well into old age.

Coleman and his colleagues examined the brains at autopsy of 15 individuals: five normal elderly people (ranging in age from 68 to 92 years), five normal younger adults (ranging in age from 44 to 55 years), and five aged individuals who had died having senile dementia of the Alzheimer's type (ranging in age from 70 to 81 years). While the dendrites of some cells seemed to have shrunk, the normal aged brains had longer and more extensive dendritic "trees" than either of the two other groups.

Dendrites in the brains of SDAT victims had either stopped growing or degenerated—the longer the history of the disease, the less extensive the pattern of dendrites. This is especially significant because the dendrites Coleman examined were in that part of the cortex which provides information to the hippocampus, an area of the brain that is crucial for memory and learning.

Coleman's is one of the first studies to indicate that there is a greater degree of growth than there is degeneration in the normal aging brain. Although his findings may represent one aspect of a lifelong process of growth in the human brain, Coleman speculates that the brain may be compensating for the loss of some of its cells over time. Perhaps at some point the brain cells that are regressing and dying begin to outnumber the cells that are surviving and growing, but Coleman was not able to find the age at which that might happen—and the oldest brain he studied was 92 years old!

BRAIN STIMULATION RETARDS AGING

For decades, scientists have been observing, studying and attempting to describe age-related changes that normally occur in the human brain. Their interest stems from the fact that the brains of normal, healthy elderly individuals frequently show a variety of changes—but it may be that when carried to the extreme, these changes result in such debilitating diseases as senile dementia of the Alzheimer's type. Now, research is beginning to find evidence that by manipulating hormone levels in the brain, medical science may someday be able to combat or delay some of the most harmful aspects of brain aging.

Several years ago, the *Special Report on Aging* highlighted the speculation of NIA grantee Philip Landfield that hormones related to stress might be responsible for some of the gradual changes in the brain during aging. To test this hypothesis, Landfield sought to retard brain aging by surgically removing the source of many stress hormones, the adrenal glands, of experimental rats. After surgery, these rats showed fewer signs of brain aging than control (intact) animals of the same age.

One of the major consequences of removing the adrenal gland is an elevation in adrenocorticotropic hormone (ACTH), a hormone secreted by the pituitary gland which has been shown to exert direct influence on both brain activity and behavoir. In their most recent research, Landfield and his colleagues at the Bowman Gray School of Medicine injected experimental animals with a low to moderate dose of a compound similar to ACTH that has an effect on behavior. They found that long-term treatment with this peptide (a class of chemicals known to stimulate brain activity) or with the brain stimulant pentylenetetrazole (PTZ) was able to slow such physical changes as brain cell loss as well as improve aging animals' ability to function on some psychological tests.

These latest tests confirm the results of Landfield's early work, lend support to the suggestion that substances such as peptides can influence the rate of brain aging, and suggest that stimulation may play an important role in the process.

The evidence that brain aging is not immutably fixed and that drug therapy might modulate the rate of change may soon have implications for healthy aging.

IMMUNOLOGICAL DEFICIENCIES INVESTIGATED AS KEY TO DISEASE IN THE ELDERLY

Understanding why certain diseases seem to be more common and more severe in older people is a primary goal of immunological research. What is commonly thought of as "aging" may be better described as a decline in the efficient functioning of the immune system, the body's protection against infection and disease.

Lymphocytes (white blood cells) are the primary cells of the immune system. There are two major subgroups of lymphocytes—T-cells and B-cells. Both types originate in the bone marrow, with the T-cells passing through and being processed by the thymus, an important organ in the immune system, before going on to perform their functions. One result of B-cell activity is the production of antibodies, proteins that neutralize foreign substances in the body known as antigens and thus render the body safe from attack by these substances. Examples of antigens are viruses, bacteria, and possible cancer cells. Various kinds of T-cells act as regulators of B-cell function while other types act directly on antigens by destroying them through a process known as lysis. Research supported by the NIA has been directed at understanding the age-related changes in these cells which might result in an increased incidence of certain diseases in later life.

For example, studies by Norman Klinman and colleagues at the Scripps Clinic and Research Foundation in La Jolla, California have shown that transplanting T-cells from the spleen and bone marrow of old mice to young mice caused increased immunosuppression (reduced defense against attack by certain antigens) in the young animals. It is not yet clear whether this enhanced immunosuppression—which is characteristic of the aged immune system—is the result of reduced formation of antibodies, formation of antibodies that are not functionally competent, or formation of functionally competent T-suppressor cells which themselves act to stop the formation of antibodies. Klinman's research also showed that the decline in T-cell efficiency in old animals occurred rather precipitously between the 18th and 21st months of life. This decreased responsiveness was apparent not only when the immune system was challenged with dinitrophenyl, an antigen commonly used in immunology research, but also with the environmentally abundant antigen phosphorylcholine. Thus, it appears that the effects of a challenge to the immune system are more serious in older individuals.

Parsottam Patel of the Trudeau Institute at Saranac Lake, New York, has shown that the diminished ability of aged mice to resist infection from the bacterium *Listeria* appears to be due to an impaired capacity of these mice to generate effective antibacterial-specific immune mechanisms (T-cells). Studies done in Patel's laboratory have shown that even though there are no age-related differences between young and old animals in the number of T-cells that are present, immune spleen cells from young animals transferred at least a thousand times more protection from a challenge by *Listeria* than did similar cells from old animals.

Another important characteristic of the aging immunological system is the increased incidence of autoimmune disease. In autoimmunity, substances in the body which were once recognized as "self," and therefore not rejected by the immune system, become antigenic—they are no longer tolerated and are attacked by (and bonded with) so-called autoantibodies. This bonding between autoantibodies and the newly recognized antigens results in the formation of immune complexes. These complexes are then deposited in body tissues and organs, causing inflammation and disease. Examples of autoimmune diseases are rheumatoid arthritis and systemic lupus erythematosus, a chronic inflammatory disease affecting the skin, joints, kidneys, and often other organs.

NIA grantee Sherman Fong, also at the Scripps Clinic and Research Foundation, is one of several investigators studying autoimmunity in humans. He has found that rheumatoid autoantibodies increase in numbers between birth and young adulthood. In addition, Fong and coworkers have shown that the relative avidity—or firmness of bonding between autoantibodies and their antigens—of the rheumatoid autoantibodies is higher in elderly adults than in young adults. Increased avidity means that the bond forming the immune complex is stronger and less likely to be broken in the elderly. The result may be that there is a potential for deposition of immune complexes leading to an increased likelihood of inflammatory disease.

Findings from these and other studies may contribute to the early detection of individuals prone to age-associated autoimmune disease, and could make possible the elimination of factors which initiate autoantibody production in humans.

SOME IMMUNE PROCESSES MAY COMPENSATE FOR AGE-RELATED DECLINES IN OTHERS

As described above, the immune system—the body's protection against disease and infection—appears to function less efficiently with age. Neither the impact of this decline on health and longevity nor the exact mechanisms that control it are fully understood as yet.

Investigators at the University of New Mexico are beginning to learn about the special compensating abilities of certain T-cells in older individuals. These T-cells (known as helper T-cells) act to regulate B-cells, which produce antibodies.

James Goodwin and coworkers are examining the production of rheumatoid autoantibodies in young and old subjects. Goodwin found that blood serum samples from healthy individuals over 70 years old had significantly higher levels of rheumatoid autoantibodies than did samples from young individuals. He then went on to show that this higher autoantibody level was the result of an interesting phenomenon whereby helper T-cell activity in old individuals appears to compensate for the reduced efficiency of old B-cells.

This preliminary finding may mean that there is not an inevitable or total decline in the aging immune system. By isolating specific immune components that either enhance or compensate for age-related changes in immunocompetence, scientists are beginning to solve some of the mysteries surrounding this complex process.

NIA RESEARCHERS LOOK AT TREATMENT OF SDAT

Investigators from at least five different scientific fields are intensively studying the possible cause or causes of senile dementia of the Alzheimer's type. At universities, hospitals and research centers around the country, scientists are looking at changes in brain chemistry, as well as the possible roles of slow viruses, immunological and genetic factors, and toxic metals. The results of this work are starting to look promising: although we still do not know the primary cause of SDAT, we may be closer to finding a cure.

In the past decade, the most consistent findings in studies of SDAT have pointed to a decrease in the activity of certain chemicals in the brain which comprise what is known as the cholinergic system. For some time it has been known that the cholinergic system is involved in both memory and learning. If, as is indicated by most recent work, there is a malfunction in the complex chemical interaction which converts choline in the brain to the neurotransmitter acetylcholine, then attempts to stimulate or revitalize the cholinergic system may at least alleviate the debilitating symptoms of SDAT.

NIA grantee Kenneth Davis is approaching this possibility of treatment by injecting patients with physostigmine, a drug which prevents the otherwise fast breakdown of acetylcholine. Based on nearly 200 infusions of the drug, Davis and his colleagues at the Mount Sinai School of Medicine find that physostigmine can improve both memory and learning in SDAT victims.

Davis is the first to admit, however, that physostigmine is not the answer to his patients' problems. The drug's effects last only 30 minutes; long-term use can adversely affect both heart and lung function; and the successes to date have been based on frequent injection of the drug, which is hardly a practical method for treatment of elderly patients. For these reasons, Davis is one of several scientists looking for a safer, longer-acting drug which will influence the activity of the cholinergic system.

Investigators who believe we are close to finding a treatment for SDAT are also exploring several other strategies for stimulating the cholinergic system. Perhaps the most work involves the use of "precursors," in which the brain is supplied with an overload of one of the principal ingredients needed for the chemical synthesis of acetylcholine. In tests of drugs and dietary supplements, researchers have attempted to increase the amount of choline in the brain with disappointing results.

As Davis' research progresses, he hopes to study another intriguing theory. If, as is now suggested, the utility of precursors depends on the level of activity in intact cholinergic neurons, then future studies might combine choline or its dietary source with drugs that enhance the "firing" of neurons.

Despite major advances in our understanding of SDAT, there is still a need for additional basic research before we can hope to treat the symptoms of SDAT victims with consistent success.

PHARMACOLOGICAL APPROACH TO SDAT CHARTED

Based on evidence relating losses of certain enzymes and nerve cells in the brain to SDAT, Edythe London and colleagues in the Laboratory of Neurosciences at the NIA's Gerontology Research Center (GRC) are exploring a novel pharmacologic approach to the disease. Rather than attempting to stimulate the neurons which produce acetylcholine or attempting to block degradation of the neurotransmitter, the GRC investigators are focusing on the acetylcholine receptor. Studies in rats indicate that this approach may be productive, since stimulation of the receptors by an outside agent may mimic natural stimulation by acetylchloline.

In an experiment that supports the possibility of such a pharmacologic approach to SDAT, a radioactive compound similar in structure to glucose was injected into live rats. Since the brain depends on glucose for energy, the activity of different regions of the brain can be assessed by measuring neuronal uptake of the compound. Brain areas that are activated take up more of the compound and show more radioactivity than quiet areas.

London found that oxotremarine, a drug that interacts with acetylcholine receptors, stimulates activity in regions of the rat brain which are important to performance in tests of memory. Especially noteworthy is the fact that oxotremarine stimulates gluclose utilization of the cerebral cortex where the major projections of acetylcholine-synthesizing neurons terminate. In SDAT, these projections degenerate, but the receptors remain relatively unaffected. Thus, local function in critical brain regions may be enhanced by direct receptor stimulants despite cell, enzyme, and neuro-transmitter losses.

Under the direction of Stanley Rapoport, the NIA laboratory is documenting the metabolic pictures characteristic of healthy old and young adults and SDAT patients. These studies will provide baselines against which to measure future clinical trials of anti-SDAT drugs.

TAMOXIFEN TREATMENT BENEFITS RABBITS WITH OSTEOARTHRITIS

Osteoarthritis, a degenerative joint disorder, afflicts 40 million Americans, most of whom are over 50. Its cause has not been pinpointed, nor has a specific treatment been found. However, an encouraging study was reported recently by investigators receiving grant support from the NIA and the National Institute of Arthritis, Diabetes and Digestive and Kidney Diseases. Itzhak Rosner, Roland Moskowitz, and associates at Case Western Reserve University have found that tamoxifen, an anti-estrogen drug used in breast cancer treatment, has a beneficial effect in rabbits with experimentally-induced osteoarthritis. According to the scientists, tamoxifen treatment results in a marked, statistically significant decrease in the amount of joint damage.

Clinicians have noted that the symptoms of osteoarthritis become worse in women past the menopause, so it has been suspected that sex hormones play a role in cartilage metabolism and the development of this disease. Various hormones have been tested, however, and found to be of no value in treating this disorder. In fact, in earlier studies by Rosner and Moskowitz, the female hormone estrogen worsened the disease. The researchers also had found that drugs used in arthritis treatment, including aspirin, corticosteroids, and the antimalarial drug Chloroquin, did not alter the disease process.

Because estrogen increased joint damage in their studies, the investigators tested the estrogen-blocking drug tamoxifen and found it significantly reduced the number of bone ulcers and the severity of "pitting" of joint cartilage caused by osteoarthritis. It is not yet known whether tamoxifen's beneficial effect is due to its anti-estrogen activity or to some other mechanism. Studies will continue to determine the drug's method of action and to assess its ability to retard the disease process and to repair already established osteoarthritic damage.

CLUE FOUND TO MANIPULATING LIFESPAN THROUGH DIET

The only scientifically confirmed method of extending lifespan in mammals appears to involve manipulation of the diet. Scientists demonstrated this more than 40 years ago in rodents. They lived longer when "underfed" in comparison with rodents allowed to eat at will in their laboratory cages.

For the first time, an effect of dietary manipulation has been found at the cellular level in the brains of aged rates on restricted diets. They have a higher density of receptors for the neurotransmitter dopamine in the corpus straitum of their brains than do rats of comparable age fed at will.

This finding is considered provocative since the corpus straitum is involved in sleeping, eating, and other kinds of motor behavior; since the receptors are cellular structures necessary for reactions to hormones and related chemicals, such as dopamine; and since loss of certain types of dopamine receptors seems to occur in human beings who have Parkinson's disease.

In the GRC experiments conducted by George Roth and colleagues, some rats were fed only on alternate days while their age peers were allowed to eat anytime. At 24 months of age, considered later life for the rat, the restricted animals showed a 40 percent loss in weight but had 50 percent greater concentrations of dopamine receptors. These concentrations were the same as those in rats aged 3 to 6 months that ate at will. Ultimately, the restricted rats had a lifespan 40 percent greater than the rats fed unlimited quantities.

The question remains whether rats fed at will die earlier from "overfeeding" or restricted rats die later from "underfeeding." Further studies of the relationship of diet to longevity may shed light on this issue.

MANIPULATING THE BIOLOGICAL CLOCK MAY IMPROVE HEALTH AND LONGEVITY

Scientists have known for many years that when animals are fed low-calorie diets, their lifespan is extended and tumor incidence reduced. Franz Halberg at the University of Minnesota has previously shown that dietary restriction produces variations in the animals' circadian rhythms. Circadian rhythms are cyclic changes in many bodily functions—such as temperature and hormone concentrations—that occur approximately every 24 hours in human beings and many other animals. These rhythms have a profound effect upon the efficient operation of many bodily functions, such as the immune system. In addition, Halbert and coworkers have recently demonstrated that more than 12 human rhythmic variables as well as circ-annual (about yearly) rhythms undergo important changes with age.

These investigators, with international collaboration, are now studying the extent to which the manipulation of circadian and circ-annual rhythms by meal timing (both with and without caloric restriction) affects health and longevity. Their findings mirror the results of standard dietary-restriction studies. But by also measuring changes in circadian and circ-annual rhythsm, the researchers are shedding new light on the mechanisms controlling increased lifespan and reduced tumor incidence in diet-restricted animals.

These results indicate that it may be possible to develop cost-effective regimens for improving the lives of the elderly if a rescheduling of rhythms could achieve in human beings what has been achieved in experimental animals using caloric restriction. Knowledge in this area would also be useful in determining the optimal timing of drug administration, improving productivity of shift workers, and increasing resistance to toxic agents.

ARGININE AND GLYCINE AID WOUND HEALING

Elderly people usually recover from surgery and from injuries such as fractures and burns more slowly than young people do. One reason may be that older bodies are less able to cope with the protein losses that accompany severe trauma. A study by NIA grantees Paul Griminger and Hans Fisher at Rutgers University offers hope that a specific type of dietary supplementation might aid wound healing in older people.

Griminger supplemented the diets of young and old rats with glycine and arginine, two amino acids that are essential components of protein, and then compared their recuperative processes with those of animals whose diets had not been supplemented. He found that wound healing was improved in both young and old animals that had received the special diet, and that this effect was especially notable in the older rats. Improvement was determined by measuring the amounts of collagen deposited at the wound sites. Collagen is a main supportive protein of skin, tendon, bone, cartilage, and connective tissue; the more collagen found, the greater the healing that has taken place.

Although both young and old rats benefited from the arginine and glycine supplements, less collagen was deposited at the wound sites in old rats receiving the amino acids than in young ones during the healing process. This indicates that supplementation is especially important for older animals.

Further research is planned to investigate the possible role of other amino acids in wound healing. Eventually, the findings may lead to better ways of treating older people when trauma occurs. The study also points to the need for further research into the specific nutritional requirements of the elderly, whose needs, in health and illness, may differ from those of the young.

BODY COMPOSITION BASELINES ESTABLISHED FOR HEALTHY PEOPLE AT DIFFERENT AGES

Using newly developed, sophisticated measuring techniques, Stanton Cohn and associates at the Brookhaven National Laboratory in Upton, New York, have made precise determinations of the amounts of muscle tissue, non-muscle lean tissue, skeletal mass, and body fat in 135 healthy people aged 20 to 80 years. The measurements reveal significant differences in body composition between the sexes and notable age-related changes in the four body components. The data will help to establish baselines that can be used in studies of metabolic disorders and wasting diseases such as cancer, which alter body composition. They should also be useful in investigating the nutritional requirements of healthy people at different ages.

Cohn, who is receiving grant support from the NIA and the National Cancer Institute, used a newly developed procedure known as the prompt gamma neutron-activation technique to measure body nitrogen, and a sophisticated whole-body counter to measure potassium. Before this study, techniques to make these measurements were not available. From the two measurements it was possible to determine accurately the mass and protein content of both muscle and non-muscle lean tissue in the human body. (Non-muscle lean tissue includes the internal organs, blood, brain, and extracellular fluid.) A third component, the skeleton, was measured by neutron-activation analysis of total body calcium. The difference between the sum of the muscle, non-muscle, and skeletal components and the total body weight yielded the fourth component, body fat.

The data collected were grouped and analyzed according to the sex and age of the volunteer. In the 73 males whose body composition was analyzed, muscle tissue decreased 45 percent from age 20 to 79. In contrast, non-muscle mass did not change significantly with age. Similarly, the protein content of muscle fell off sharply, but the protein content of non-muscle tissue decreased little, if at all. Significantly, the *total* body protein content fell only 14 percent from age 20 to 79.

The 62 women studied had an average of 50 percent less muscle mass than the men, and their non-muscle tissue was 14 to 29 percent lower. However, the percentage of body fat in women was twice that of men. These differences became greater with age. Skeletal mass decreased with age in both men and women, with a greater rate of decline in women beginning at about age 50, due in large part to the loss of calcium after menopause.

The measurement techniques and information on body composition described in this study can be used as the basis for a broad range of research including that on nutrition and exercise, as well as on research involving diseases affecting the elderly. For example, the finding that there is a relatively slow loss of total body protein emphasizes the potential importance of this nutrient throughout life. Similarly, the knowledge that muscle is especially vulnerable to the aging process suggests that older persons may need to increase their physical activity to offset this decline. The data collected may also be helpful in exploring the causes of and improving treatment for disorders such as osteoporosis, a bone-thinning condition which affects many elderly people.

AGING DOES NOT IMPAIR THE HEART MUSCLE

If it is free of disease, the heart of an old person pumps about as well as that of a young adult. Thus, any problems related to the older heart's ability to move blood must be considered the effect of disease, not aging.

This striking conclusion, reached recently by scientists involved in the NIA's Baltimore Longitudinal Study of Aging (BLSA), conflicts with common notions that uncomfortable and activity-limiting cardiovascular symptoms are inevitable in old age.

Collaborating in the studies were scientists at the GRC and The Johns Hopkins Medical Institutions. The Johns Hopkins scientists include Myron Weisfeldt and Gary Gerstenblith, both GRC alumni. Among the NIA staff scientists in the study were Edward Lakatta, Jerome Fleg, and Reubin Andres.

Although the sturdiness of the healthy heart in old age may be reassuring, the investigators point out that coronary artery disease (CAD) is probably twice as prevalent among older men as previously documented. Nearly all major epidemiologic (population-based) studies may therefore be in error because attempts were not made to measure latent (hidden) CAD.

To reach their conclusions, the investigators used highly sophisticated methods for detecting any significant narrowing of the coronary arteries in community-living volunteers who had no cardiovascular symptoms. Traditional methods of screening for CAD miss many individuals with significant arterial narrowing, so the prevalence rates based on these methods may be misleading.

Conventional investigations employ electrocardiograms taken with the subject at rest. They show that 20 to 30 percent of older people have CAD. However, post mortem examinations disclose a 50 to 60 percent rate. The NIA studies help to resolve this discrepancy by using a method that detects CAD accurately in the living person without the need for painful diagnostic procedures. Individuals exercise vigorously while an electrocardiogram is made. During the exercise—walking "uphill" on a treadmill—a solution of a radioactive form of the element thallium is infused through a catheter (tube) into a vein. The amount of radiation exposure is considered safe, less than an individual would receive for a series of gastrointestinal X-rays to diagnose an ulcer.

When the thallium has reached the heart, a gamma-ray scanner is placed over the research subject's chest to detect the radiation. The scanner in conjunction with a computer produces an image that shows how well the heart muscle has been perfused with blood containing the thallium. A reduction in blood flow due to narrowed arteries causes a "hole" to appear on the scan.

Stress/thallium tests of the heart were performed on 233 BLSA volunteers and the results were compared with their health histories and resting electrocardiograms. The stress/thallium tests showed CAD occurring twice as often as had been indicated by the conventional tests. For example, while the latter showed 22 percent of individuals in their seventies to have CAD, the addition of thallium scanning showed 56 percent with CAD.

These findings caused the investigators to wonder how the older heart performs in the absence of latent CAD. Many researchers have reported deteriorated pump function with age in human subjects. However, these studies generally did not rule out latent CAD.

To get at this issue, the investigators did a second study in which 36 volunteers who had been found free of CAD on stress/thallium tests were examined with another scanning technique. Using technetium 99m, a radioactive element that stays in circulation rather than dispersing into muscle tissue, the scientists obtained scans of the volunteers during maximal exercise on a stationary bicycle. The scans allowed measurement of the quantity of blood ejected with each stroke of the heart.

Traditional data suggested that cardiac output declined with age, so that a 90-year-old person's heart would pump at half the capacity of a 20-year-old's. The NIA examination, however, showed no age-associated reduction in pumping. Thus, reduction indicates disease, not aging.

This study also demonstrated how the aging heart compensates for an inability to achieve as high a rate of pumping as the younger heart. The older heart muscle compensates by enlarging, thus increasing its capacity to eject blood with each stroke.

By identifying individuals in the BLSA who have latent CAD, the GRC scientists hope to answer a variety of clinically important questions:

—Are the risk factors for developing latent CAD the same as those for overt CAD?

—Why does age appear to be the most important risk factor for the development of CAD?

—How good are stress tests of heart function as predictors of subsequent coronary events, such as angina (severe chest pain), myocardial infarction (heart attack), and sudden death?

INVESTIGATOR FINDS MODEL FOR HUMAN PRESBYCUSIS

Fifty percent of the 25 million Americans over the age of 65 suffer from some form of hearing impairment. The most prominent cause of this hearing loss is presbycusis, which is a gradual decline in hearing ability, especially for high-pitched sounds.

Like "senility," presbycusis is a term which is applied to a set of symptoms that may be cause by a variety of factors. Unlike "senility," it is still thought by many to be a normal consequence of aging rather than a disease. Investigators have little understanding of the mechanisms causing the form of hearing loss that is attributable to old age alone.

At the Boston University School of Medicine, Martin Feldman has developed an experimental model to study the onset and development of presbycusis as well as the factors which influence the degree of severity of hearing problems. Feldman's work involves the study of age-related changes in the rat cochlea, that part of the inner ear equipped with auditory nerve cells which translate sound into messages sent to the brain. Each of these tiny specialized cells is lined with microscopic hairs which are stimulated by sound. In the rats he has observed, as in human presbycusis, Feldman finds that there is a progressive loss of these tiny hairs over time.

Feldman's research may eventually lead to a better understanding and management of hearing impairment in the aged.

NIA GRANTEE EXPLORES SLEEP AND SLEEPINESS

It is not unusual to hear of elderly people complaining about the amount of sleep they do—or do not—get. It has been known for over a decade that nighttime wakefulness and the number of awakenings increase as a person ages. What causes older people to experience disrupted, fragmented sleep during the night? Do people need less sleep as they age? What effects do sleep and wakefulness have on a person's ability to function during the day? And why is it that some older people don't seem to have any complaints about their sleep?

With support from the NIA, William Dement is conducting a detailed exploration of sleep and wakefulness in older people at the Stanford University Sleep Research Center. What he finds is that the ability—rather than the need—to sleep decreases over time. Furthermore, nearly all older people awaken frequently during the night, including those who feel that they are getting "a good night's sleep."

In the initial stages of their study, Dement and his colleagues selected and examined as many as 100 healthy individuals between the ages of 62 and 86 who had no specific complaints related to sleeplessness or sleepiness. In order to obtain information on nighttime sleep and to evaluate daytime alertness, the researchers monitored bodily and brain functions around-the-clock for 48 hours.

The most notable finding in the early part of this project was that more than 35 percent of the elderly volunteers experienced numerous episodes of respiratory disturbance while asleep. From several score to several hundred times per hour, these subjects would stop breathing, awaken briefly during the period of stalled breathing, and resume normal respiration without ever being aware of the problem. Those subjects whose sleep was most radically disturbed by these episodes of "sleep apnea" were also the sleepiest during the daytime.

Dement's initial observations suggest that old people are frequently the victims of sleep apnea syndrome and that they suffer considerable daytime consequences. In fact, Dement speculates that the decrease in daytime alertness associated with sleep-related respiratory disturbance may lead to increased risk of accidents among the elderly, and may even be mislabeled as "senility" in extreme cases. There is also some suggestion that disturbed breathing may lead to other physical problems. Epidemiological evidence from Italy has shown a highly significant association between heavy snoring (which is the primary characteristic of one type of sleep apnea) and cardiovascular diseases. Moreover, prescribing sleeping pills to the elderly might further depress breathing and heighten the risk of sudden death during sleep.

Clearly, future work from the Sleep Research Center will take on increasing clinical significance as Dement and his colleagues explore the relationships among sleep/wake patterns, health and longevity.

INTELLIGENCE CAN IMPROVE WITH AGE

The idea that certain changes in cognition can be expected as part of the normal aging process is widespread. People who study human development have long believed that the functioning of the human mind levels off and eventually declines throughout the adult years. Today, the growing number of healthy, active adults surviving into their seventies and beyond challenges this negative sterotype of old age—so, too, do longitudinal research studies that have been tracing changes in the same people as they age.

K. Warner Schaie, Director of the Gerontology Research Institute at the University of Southern California, recently completed a 21-year study of intellectual performance in aging adults. This research received support in its final years from the NIA. During the course of the study, Schaie and his colleagues examined several thousand healthy, community-living volunteers ranging in age from 22 to 81 years. Subjects were called back at 7-year intervals for retesting. The most positive and provocative finding of this work is that at all ages the majority of people studied maintained their levels of intellectual competence—or actually improved—as they grew older.

Between the ages of 60 and 67, less than 30 percent of the subjects showed a dropoff in mental and psychological performance. Among the older age groups—subjects who moved from their eighth decade to their ninth decade during the course of the study—between 35 and 44 percent showed some decline. Interestingly enough, there was a significant minority in each age range who continued to improve. Even between the ages of 74 and 81, almost 10 percent of the people tested performed better than they had at younger ages. Schaie's findings come a long way from the previously-held belief that intelligence peaks at age 16 and then declines because of aging!

Schaie's analysis of his data by sex, cohort (groups of people born around the same time), and ability to perform on selected tests (such as verbal meaning, spatial orientation, inductive reasoning, mathematical ability, and word fluency) show no single uniform pattern across the adult lifespan. There are vast differences in intellectual change as people age, yet Schaie's work has begun to shed some light on what factors might be implicated in individual variations. First of all, it appears that such physical conditions as cardiovascular disease can undermine cognitive function (see *Special Report on Aging: 1979*). Secondly, it is clear that people who are raised in advantaged socio economic environments are more apt to attain high levels of intellectual functioning and to maintain such function into old age. Thirdly, it appears that middle-aged people whose lifestyles and attitudes are flexible are likely to maintain their intellectual abilities later in life. The evidence that changes in the environment and in education can affect intelligence in old age is of extreme interest to the scientific community and a source of hope for future generations.

RESEARCH APPROACHES A MORE ACCURATE DIAGNOSIS OF DEMENTIA

What happens when an old person starts to show signs of "senility"? With luck, someone—perhaps a relative—will realize the importance of going to a physician to find out what is causing the problem, if it is curable and, if it is not, what can be done to help.

The first health professional the victim contacts is likely to be an internist, a geriatrician, or a general practitioner. Because of the variety of conditions that can cause what is medically known as senile dementia—and also because of the wide range of symptoms—the patient may eventually consult or be examined by a neurologist, a psychiatrist, a psychologist, a radiologist and/or a social worker. Before the family is satisfied that the examination has been complete, they might be exposed to the terminology used by various specialists: senile dementia, Alzheimer's disease, organic brain syndrome, brain failure and senile psychosis. The accurate diagnosis of "senility," by whatever name, is clearly a challenge for physicians. But are health professionals from various disciplines using the same guidelines to examine patients, make diagnoses, and develop courses of treatment?

According to a study at the Philadelphia Geriatric Center, professionals from different clinical disciplines generally agree in the diagnosis of senile dementia. NIA grantee Samuel Granick has found that despite their dependence on the tools of their individual specialties, almost all of the clinicians involved in his research felt that severe memory loss, disorientation and a decline in mental functions are the most distinctive symptoms of senile dementia. The physicians studied conducted extensive medical, social and behavioral evaluations of 111 elderly volunteers.

As part of their research, Granick and his colleagues also developed a list of 141 medical and psychological factors which can be used to detect senile dementia in its earliest stages. This list included a few purely medical variables, such as a history of heart problems, which might distinguish individuals with moderate to severe forms of dementia from nondemented subjects. None of these medical factors were sensitive enough to detect mild forms of dementia. On the other hand, tests which measured aspects of psychological function showed the extensive and seriously deteriorative effects of senile dementia. Combining psychological tests made it possible to single out patients who were only mildly demented. According to Granick, performance on behavioral or psychological tests would appear to be more useful than the standard medical and biochemical measures currently used in the diagnosis of senile dementia.

Granick further refined his list of factors and came up with 15 variables—most of which deal with the quality of intellectual function—which together can serve as a basis for the diagnosis of senile dementia. Using a step-by-step process to measure such functions as mental status and memory, Granick accurately classified 93 percent of a smaller group of volunteers in the study as either mildly demented, suffering from moderate to severe dementia, or nondemented.

Since there has never been a single reliable and valid test to diagnose senile dementia in its earliest stages, Granick's work may prove extremely useful to physicians.

STRESS IS VIEWED FROM A NEW PERSPECTIVE

Scientific research has traditionally suggested that stress associated with such major life events as marriage, childbirth, or the death of a loved one can affect general health. NIA grantee Richard S. Lazarus, working at the University of California, Berkeley, finds that it may not be the events themselves which produce stress, but how the individual evaluates and copes with them.

Lazarus and his colleagues assessed some of the emotional responses of 100 men and women 45 to 64 years of age to daily stresses as well as major life events. Subjects kept a daily log and responded to questionnaires and interviews about sources of stress, from minor annoyances to major problems, and how they felt—happy, excited, guilty, or fearful, for example.

Lazarus found that the frequency of the irritations of everyday life—such as traffic jams, broken appointments, or not having enough time—as well as the uplifts, were more powerful predictors of psychological and physical health and morale than were major life events.

A subject's view of a problem had an important impact on coping. Participants who felt they could change a situation tended to use problem-solving approaches, rather than emotion-focused responses such as seeking sympathy, feeling bad, or blaming themselves.

Counter to some long-held theories that individuals have set patterns of coping, the study participants varied greatly in their coping techniques. They used both problem-solving techniques and emotion-regulating responses (such as positive thinking, denial, avoidance, and humor) in virtually every stressful encounter. In general, age or sex did not affect coping behavior.

Depressed persons in this study faced the same types of problems as nondepressed persons, but tended to require more information before they could act. They employed fewer problem-solving techniques, sought more emotional support at work, and engaged in more wishful thinking and self-blame at home.

By examining coping and stress and how ways of coping might affect—or be affected by—general health, the researchers hope to lay a foundation of knowledge useful in teaching coping skills in later life.

COPING BEHAVIOR RELATES MORE TO KIND OF STRESSES ENCOUNTERED THAN TO AGING

Another NIA study on stress has examined whether older people tend to use escapist fantasy, hostile reactions, denial, and withdrawal in dealing with life stresses.

The notion that they use such primitive and passive mechanisms of coping is common. But scientists in the GRC Stress and Coping Section find that middle-aged and older adutls in the BLSA tend to resort somewhat less often than young adults do to escapist fantasy, wishful thinking, and hostile reactions in dealing with stresses.

One reason why erroneous notions about old age arise is that the stresses in this phase of life are different from or occur with greater frequency than those in younger adulthood. Therefore, coping responses in this period may not be characteristic of old age but of the type of stress older people encounter, according to Robert M. McCrae and Paul Costa.

To test this theory, McCrae and Costa established three categories of life stress: (1) threats—events that involve a present or future danger, such as chronic illness, being sued, and problems in finding a job; (2) losses—events that require adaptation to some harm that has already occurred, such as the death of a parent, marital separation, or robbery; and (3) challenges—events that open up favorable but taxing opportunities, such as a new career, pregnancy, or election to office.

Participating in the study were 154 men and 101 women divided into three age groups: 24 to 49, 50 to 64, and 65 to 91. Participants completed a checklist of recent events in their lives. From each completed list, the investigators chose a particular event. A list of ways of coping was presented and participants were asked to indicate if they had ever used one or another of the coping methods to deal with the selected life event.

The results showed a number of ways in which individuals in the three age groups coped differently. For example, older participants tended to use less positive thinking, self-blame, and humor than did younger participants. The elderly were more likely to take things one step at a time.

However, although the use of coping mechanisms was different in the three age groups, age itself was not responsible for most of the results. Instead, the findings reflect the fact that individuals of different ages face different kinds of stress.

The data indicated that the older age group experienced fewer challenges and more threats than the younger groups did. Losses occurred with about equal frequency at all ages.

The BLSA data also show that the type of stress influences the selection of coping mechanism. For example, coping by taking rational action or by using humor is more frequent when the stress is a challenge than when it is a loss. Faith is a more common choice when the stress is a threat.

When these factors are taken into account, most of the age variations in coping disappear. Coping seems to differ by age group because of differences in the stresses encountered.

THE DEATH OF A SPOUSE CAN AFFECT LONGEVITY

Social scientists have long speculated that the grief which follows the death of a spouse causes as much, if not more, stress than any other event in a person's life. In fact, the suggestion has been made that such stress can lead to the premature death of the survivor.

In a recent study by The Johns Hopkins University, NIA grantee Knud Helsing expended the scope of previous studies and took a closer look at the effect of bereavement on mortality. According to Helsing, the death of a spouse can take as great a toll on the survivor as social scientists have always suspected, but only on men.

Comparing more than 4,000 widowed people between the ages of 18 and 64 to married people of the same age, Helsing found that widowed men were more likely to die prematurely. The same did not hold true for the widowed women in the study.

Helsing's work also debunks certain myths about bereavement. The first 6 months after the death of a spouse—perhaps the most intense period of grief—did not show a significant increase in mortality among either men or women. The death rate for widowed males remained higher than in the married population during the 12 years that Helsing followed them.

Helsing and his colleagues also took a closer look at the lifestyles of the people they studied. When there was some social support during the period of grieving and beyond, there were fewer deaths. Social support could mean anything from remarrying to living with a relative or friend or going to church regularly.

Numerous scientific studies have attempted to determine why a women's life expectancy at birth is greater than a man's. Perhaps further studies will find out why this advantage women seem to enjoy extends even to periods of bereavement.

WOMEN'S RETIREMENT DECISIONS STUDIED

With the long-term trend toward increased labor force participation by women, questions about women's retirement are pressing. What, for instance, are the implications of a woman's work history pattern, and how does her pattern relate to that of her husband?

NIA grantee Angela M. O'Rand, working at Duke University, analyzed findings from the Social Security Administration's Longitudinal Retirement History Study on retirement patterns of husbands and wives as well as individuals. She found that joint retirement is common among couples in which both the husband and wife have worked extensively. In addition, couples in this sample were found to retire largely in response to the age, health status, pension coverage, or other characteristic of the husband rather than the wife. When men and women were compared as individuals, economic factors tended to influence men's retirement decisions while status factors, such as occupational prestige, tended to influence women.

Current studies are tracking a different generation of women who, despite family responsibilities, are staying in the work force longer. An understanding of work and retirement patterns may help pension policies adapt to social, economic, and population changes.

A LARGE FAMILY MAY MEAN MORE ATTENTION FOR AGING PARENTS

Do large families provide more emotional and physical support than small families do for parents as they grow older? NIA grantees Joan Aldous and David Klein recently examined the relationship between family size and the frequency and quality of contacts between parents and their adult children who have left home. At the University of Notre Dame, Aldous and Klein surveyed 124 families drawn from a sample of the University's graduates. Most of the parents were in their sixties. The families ranged in size from 1 to 11 children, some of whom still lived at home.

Aldous and Klein found that physical support per child was greater in the larger families. Of the children who had left home, those from larger families were more likely to help with shopping, transportation and housework. In all of the families surveyed, the parents were more apt to receive than give comfort, sympathy, and advice, although one-third of the parents felt that their adult children should discuss important decisions with them.

In all of the families, many of the children who left home remained close; half lived within an hour's drive of their parents. Those parents who had more frequent contacts with their own parents and siblings during the child-rearing years more often expressed disappointment in the quality of contact with their children, possibly because their expectations were higher. However, those same parents also tended to report greater contact with their children who had left home. Two-fifths of all the parents said they would like more contacts with their children.

With the decline in family size, the growing proportion of women in the work force full-time, and the increase in divorce and remarriage, it is of great importance to learn more about the effect of family relationships on the health and well-being of older people.

NIA DEVELOPS COMPUTER MODEL OF THE ECONOMY

The long-term nature of a social security system's processes and commitments make it extremely sensitive to economic and population changes. For example, the retirement income system will have to adapt to changing fertility rates and life expectancy in the coming years. In considering alternative approaches, it is important to have a means of predicting the impact of various social and economic factors on the retirement income system. The NIA Epidemiology, Demography, and Biometry Program has therefore funded the development of an extensive computer model that can simulate the behavior of the economy given various sets of assumptions. This Demographic Macroeconomic Model, as it is called, has the capacity for projecting shifts in economic growth, the labor market, and the major components of the retirement income system. The model also allows an examination of the interrelationship between the Social Security system and private pension plans.

FUNDS FOR PROGRAMS ON AGING

[In thousands of dollars]

	1978	1979	1980	1981	1982 estimate
Public Health Service: National Institutes of Health: National Institute on Aging	35,057	56,472	69,725	75,649	[1] 84,186

[1] Based on the President's original submission to Congress; a current proposal for a 12-percent reduction is being considered, which, if implemented, would change this figure to $74,084.

NATIONAL INSTITUTE OF ARTHRITIS, DIABETES, AND DIGESTIVE AND KIDNEY DISEASES

The programs of the National Institute of Arthritis, Diabetes, and Digestive and Kidney Diseases (NIADDK) encompass a wide range of common and important chronic diseases, which affect millions of Americans and exact a devastating toll of chronic disability, pain, financial loss and premature death, particularly from the aged. It is the Institute's major mission to promote and conduct research on the etiology, diagnosis and treatment of these diseases. Of particular interest to the aging population, NIADDK funds research in the areas of arthritis, maturity-onset (type II) diabetes, benign prostatic hyperplasia, and nutrition. In addition, the Institute's Multipurpose Arthritis Centers and Diabetes Research and Training Centers have educational and community demonstration programs aimed at increasing public awareness of these diseases and their treatments.

One of the goals in the area of arthritis is to gain a better understanding of the etiology of osteoarthritis and related joint diseases and to develop means for prevention and better treatment. Studies are underway to develop or improve procedures for repair or replacement of injured or diseased joints. Osteoporosis (loss of bone mineral) is a condition to which aging women are particularly prone. It results in pain, and predisposes to fractures primarily of the hip, wrist and vertebrae, and loss of height and spinal deformity. Research is aimed toward understanding how factors such as postmenopausal hormone decline, lack of exercise, and reduced calcium levels influence the incidence of problems caused by this disease.

Maturity-onset diabetes tends to develop in late middle or old age. Patients with this disease are presumed to have an inherited predisposition to this condition; however, evidence suggests that in many individuals the clinical symptoms of this disease can be delayed, controlled or prevented through weight control, proper diet and exercise. New insights into these factors may aid in reducing the numbers of persons developing this type of diabetes and may produce a better means of control for those who do.

Studies are being conducted to determine the cause of benign prostatic hyperplasia (BPH), a major medical problem affecting more than 50 percent of men by age 50, and 90 percent by age 80. This disorder is an eventual lead-in to more serious problems, such as chronic urinary tract obstruction and infection, kidney disease and possibly prostatic cancer. Surgical removal of the prostate gland is an effective treatment; however, many aging men are poor surgical risks. Preventive measures and alternative treatment methods are being sought in hopes of reducing the incidence of BPH and its consequences.

NIADDK support in the area of nutrition research is vital. Obesity has become a major health problem in the United States because of its direct and indirect effects on the health of the individual. Obesity may aggravate hyptertension and increase the risk of cardiovascular disease; it facilitates osteoarthritis of the weight-bearing joints; and promotes the emergence of maturity-onset diabetes. One of the goals of the NIADDK's programs in the area of nutrition is to provide dietary guidance to the various subgroups of the population, including the aged, to aid in the prevention of dietary deficiencies or detrimental excesses that may lead to various disorders.

As the U.S. population ages, the number of people at risk for the chronic, disabling diseases studied with NIADDK funds is expected to increase sharply. The Institute is committed to fostering fundamental and clinical research toward improving the Nation's means of coping with these diseases. NIADDK funds a varying number of grants in the disease categories mentioned. Because research activities which *specifically* address the aging process are assigned to the National Institute on Aging, NIADDK has few projects in this category. These are listed below:

Project No.	Project title	Fiscal year 1981 funding
5 RO1 AM13710-4B	Metabolism of testosterone (Androgens) in man	$52,621
5 RO1 AM21190-09	Lifestyles and bone densities of the aged	180,360
2 RO1 AM07912-09	Longitudinal study of pre-osteoporosis population (women)	156,640
5 RO1 AM10202-08	Nutritional requirements of aging humans	689,487
5 RO1 AM28176-3B	Age and liver adrenergic receptor systems	63,646
Total		1,142,754

NATIONAL CANCER INSTITUTE

While the primary focus of research supported through the National Cancer Institute does not deal specifically with aging or the elderly, this area is an integral part of the study of cancer. It is thought, for instance, that the aging and carcinogenic processes may be directly related. Cancer, moreover, can occur at any age, but some cancers seem to strike particularly heavily at certain age groups. The study of certain cancers, therefore, may result in particular interest in the over-65 age group.

Investigation of the relationship between aging and cancer, as well as the study of cancers of the elderly is, like all biomedical research, a slow and painstaking process and does not change dramatically from year to year.

DIVISION OF CANCER BIOLOGY AND DIAGNOSIS

Research in the Division of Cancer Biology and Diagnosis (DCBD) has been concerned primarily with studies of abnormal, accelerated aging phenomena in humans who have diseases characterized by inherited defects in mechanisms which repair damaged DNA. Since DNA is the important chemical of human chromosomes which directs the metabolism of the cells, it is crucially important that it be maintained in an undamaged condition. The principal organs we have been interested in are the skin and the central nervous system. One feature of sun-exposed aged skin in the elderly is the development of skin cancers. From our studies of the disease xeroderma pigmentosum (XP) we have learned a great deal about the role of DNA repair processes in the development of sunlight-induced skin cancers. We have also learned from studies of XP that DNA repair processes protect all normal human beings from premature death of nerve cells. These studies are shedding light on possible pathogenetic mechanisms responsible for the premature deaths of neurons in certain degenerative disorders of the nervous system, e.g., Huntington's disease. It is possible that information gained from studies of these degenerative diseases of the nervous system may elucidate mechanism involved in normal, as well as abnormal, aging of the human brain.

There follows below an introduction to these topics from relevant publications: (Robbins, J. H. and Moshell, A. N., Journal of Investigative Dermatology, volume 73, pages 102–107, 1979) (references have been deleted):

"Xeroderma pigmentosum (XP) is an autosomal recessive disease in which patients exposed to small amounts of sunlight rapidly manifest skin changes resembling the chronic solar damage that occurs in normal persons who have received excessive sun exposure over many years. Such cutaneous damage comprises degenerative changes, including atrophy of the epidermis; "solar degeneration" of the dermis; and development of pigmentation abnormalities; telangiectases, actinic keratoses, and cutaneous malignancies. The primary pathogenic abnormalities in XP are inherited defects in DNA repair mechanisms. Even though individuals without XP do not have such inherited defects, it seems highly probable that at least some of the chronic solar damage to their skin develops through physicochemical pathways similar to, if not identical with, those producing the damage in the skin of XP patients. Thus information obtained from studies on XP patients and their cells may elucidate mechanisms resulting in solar damage in normal persons.

One aspect of the definition of "aging" expounded by Montagna and Parakkal is especially pertinent to the premature development of chronic solar damage in XP patients. " 'Aging' may mean either growing old or maturation. Since (in the former context) the word usually connotes loss of function, so-called age changes often apply to degenerative alterations rather than to those that are an integral part of the normal development of tissues. In this discussion, age changes encompass all of these, from embryonic life through senescence." In light of this definition, the premature solar skin degeneration in XP-patients can properly be referred to as an abnormal aging of the skin. Similarly, the premature death of neurons that results in the neurological abnormalities present in certain XP patients is also properly considered an abnormal aging process. The abnormal aging of XP skin and of the XP central nervous system is the result of inherited defects in the patients' DNA repair processes. However, since XP patients differ relevantly from other human beings only by virtue of their homozygosity for certain mutations in genes controlling DNA repair processes, we can conclude that certain levels of the functional capacity of these gene loci are required for the prevention in all normal human beings of the premature aging that occurs in XP patients.

OFFICE OF THE DIRECTOR

OFFICE OF CANCER COMMUNICATIONS

The Information Projects Branch (IPB) of the Office of Cancer Communications, conducts wide-ranging information planning and dissemination programs. As such, IPB reaches specific target audiences, including the aged, with information about cancer.

Two programs have components related to the aged:

(1) The breast cancer education program disseminates current information about breast cancer to women at high risk to the disease, including those at highest risk—women age 50 and older. Program materials are carefully developed, based on the needs of this audience, and tested to ensure their appropriateness and comprehension among the target audience. Further, organizations who have as a constituency older women—such as religious and social groups—have been involved in helping NCI disseminate breast cancer information to the target audiences. While this program does not exclusively reach women age 65 and over, a significant portion of the program is designed specifically for women age 50 and older.

(2) The coping with cancer program disseminates information to patients, their families and associates, concerning cancer diagnosis, treatment, rehabilitation, continuing care, and how to cope with the disease. As most cancer patients tend to be older, this program serves to help reach the aged more than other groups, and often these cancer patients are most in need of supplementary information. Working with health professionals, the Coping program seeks to provide help in coping with the disease and its treatments. While there is no component of this program established specifically for the aged, it does serve this population more than others, due to the nature of the disease.

CANCER INFORMATION CLEARINGHOUSE

Information about cancer educational materials and patient educational material is a significant resource to health professionals who deal with cancer and provide care for patients and families. The Cancer Information Clearinghouse, a service of the Office of Cancer Communications, collects information on public, patient and professional educational materials. The Clearinghouse file contains bibliographic information on 8,000 items useful in cancer education programs. These citations include pamphlets, brochures, audio/visuals and other materials used in developing educational programs.

Health professionals, who serve public audience and patients, can obtain needed information on cancer prevention and treatment via published bibliographics, information packages and custom searches of the Clearinghouse computer data base. These services are available at no charge to health agencies and other groups, such as medical information centers, hospital patient educators and voluntary heatlh organizations. This approach links organizations to an information resource and multiplies the Clearinghouse outreach efficiency while promoting the effectiveness of individual organizations.

Since cancer afflicts many older Americans, educators and communications professionals dealing with aging populations may use the Clearinghouse to learn of new materials, keep aware of cancer subject-matter coverage and to research the need for materials development.

Clearinghouse bibliographic publications with special value to those working with older Americans include "Nutrition for the Cancer Patient," "Patient Education for Ostomates," "Patient Rights," "Screening and Diagnosis," and "Cancer Treatment." Recently the Clearinghouse has, with the cooperation of the National Institute on Aging, intensified the collection effort involving program and other materials that have been specically developed for use with older Americans with cancer. These materials will add value to the Clearinghouse collection and will result in the Clearinghouse continuing as a significant information resource for health professionals working with the aging.

DIVISION OF RESOURCES, CENTERS, AND COMMUNITY ACTIVITIES

CANCER CONTROL PROGRAM

On September 21–23, 1981, the National Cancer Institute (NCI) and the National Institute on Aging (NIA) held a working conference: Perspectives on Prevention and Treatment of Cancer in the Elderly. The conference was held at the National Institutes of Health (NIH) Lister Hill Center, Bethesda, Maryland. Conference goals were to:

(1) Identify, organize, and synthesize information from oncology, geriatrics, gerontology, and relevant fields which is concerned with improving prevention, early detection, and diagnosis of cancer in older persons, and treatment, care, and recovery processes of elderly cancer patients.

(2) Disseminate the useful information so as to improve and strengthen practices in prevention, screening, detection, diagnosis, pretreatment evaluation, and treatment of cancer for older persons.

(3) Recommend research efforts in selected areas where knowledge is unavailable or ambiguous, and intervention techniques which merit additional exploration and development.

The conference was a culmination of an initiative begun in late 1979 within the context of the cancer control mission of NCI's Division of Resources, Centers, and Community Activities (DRCCA). DRCCA's cancer control mission includes the responsibility to identify, field test, evaluate, demonstrate, and promote the widespread application of available and new methods for reducing the incidence, morbidity, and mortality from cancer.

The genesis of the conference grew out of a concern that use be made of the accumulated knowledge existing in the clinical areas of cancer and aging. The underlying notion for the conference was that the older segment of our population requires special attention as a target group. There is ample evidence that the majority of cancers occur in the age group over 65. More than 70 percent of all cancer deaths occur after 60 years of age; almost 60 percent of all cancer deaths occur after 65 years of age. It was felt, by NCI staff, that an examination of the unique problems of the elderly with respect to cancer that physicians in both fields face could create a useful knowledge base for other practicing health professionals. NIA was invited to cosponsor the conference.

A group of 38 scientists and practitioners from the fields of oncology, geriatric medicine, gerontology, epidemiology, and the social sciences convened to discuss their mutual concerns regarding cancer prevention and treatment in the elderly. Since the meeting was open to NIH staff, other interested professionals and the general public, the working group also had the benefit of their contributions to the dialog. In all, there were approximately 70 persons in attendance throughout the conference days.

Conference discussion topics centered on (1) health behavior, illness behavior, and early detection of cancer in the elderly; (2) influence of old age on cancer patient treatment and care; (3) sensitivities of older cancer patients to conventional forms of diagnosis and treatment; (4) balancing the treatment and care priorities; and (5) socio-emotional and economic consequences of cancer for the older person. In addition, the agenda called for addressing four specific cancers—breast, colo-rectal, prostate, and skin. Prevention topics included monitoring and screening issues as well as nutrition problems concomitant with both the process of aging and the disease condition of cancer.

Deliberations in this clinically-focused conference were in the exploratory mode. A vast range of issues that exist in both fields of cancer and aging were discussed. The conference raised many questions regarding the current patterns of care for elderly cancer patients and pointed out that there is a dearth of data on many issues at the clinical interface of cancer and aging. The conference was a good beginning to bring together a great deal of information which is continually being generated in both geriatric medicine and oncology. Research gaps (e.g., in epidemiological studies, in clinical trials; on tumor behavior as related to age; on pharmacokinetics and pharmacology, etc.) were identified.

A conference proceedings is being prepared for dissemination to the wider audience of community physicians and other health care professionals (who are neither oncologists nor geriatricians), but who have a need and desire to know about the important medical and social considerations involved in dealing with the older-aged person regarding cancer prevention and treatment.

NATIONAL ORGAN SITE PROGRAM

The National Organ Site Programs Branch consists of grant supported National Projects of targeted cancer research, each project oriented toward cancer at a specific organ site. Currently, there are National Organ Site Projects concerned with cancers of the urinary bladder, large bowel, pancreas and prostate. Although the population affected by cancers at these organ sites is broadly based in terms of age, bladder and prostatic cancers at these organ sites is broadly based in terms of age, bladder and prostatic cancer tend to be heavily associated with, but not limited to, the over 65 age group.

Data from the SEER program of the Epidemiology Branch, NCI, indicate that the median age of men and women at the times of initial diagnosis of bladder cancer are 69 and 72 years, respectively. There are 24,100 new cases of bladder cancer in men and 9,300 new cases in women each year. The median survival after diagnosis is about four years. Research on bladder cancer is being carried out under the aegis of the National Bladder Cancer Project (NBCP), one of the NCI Organ Site Programs. Because bladder cancer is a chronic disease which extends over a long portion of a patient's life, as long as 15 years, it is important that basic and clinical research take into account the prolonged natural history of the disease.

A close and effective relationship between basic and clinical research workers is being fostered by the NBCP. An example of this cooperation, and of the beneficial result which it can produce, is the development and use of the drug cisplatinum in the treatment of advanced and metastatic bladder cancer. This compound was first tested for its efficacy in bladder cancer in an experimental animal test system developed through the NBCP. Persuaded by its effectiveness in this experimental system, the compound was tested through clinical trials, where it was shown to be effective in patients. The next step was more extensive clinical trials, and these are now being conducted by a collaborating group, Clinical Collaborative Group A (CCGA), of several institutions across the country, all working through the National Bladder Cancer Project. The organization of CCGA is based upon the concept that bladder cancer is a relatively slow progressive disease and that increased understanding of the progression for various subgroups of patients under treatment will contribute to improved therapy through improved diagnosis and the classification of patients. Consequently, a basic protocol of this group is a study of the natural history of bladder cancer in all patients admitted by the participating physicians.

A multidisciplinary research program has been developed by the NBCP to encourage collaboration and effective exchange of information between clinical and laboratory scientists engaged in studies related to bladder cancer. Studies are supported which seek (1) to identify carcinogenic factors and develop methods for minimizing their effects; (2) to identify new high risk human populations; (3) to increase understanding of bladder carcinogenesis and find methods for interfering with this process; (4) to increase knowledge of the pathogenesis of bladder tumors and develop means for interrupting this sequence of events; (5) to develop improved methods of detection and diagnosis and to find better means for matching diagnosed patients with the most effective and specific treatment regimens; and (6) to identify better means for improving the quality of life as the post-treatment interval is extended.

Information derived from studies on bladder cancer carcinogenesis is providing a basis for promising new approaches which are being pursued. The demonstration that carcinogenesis of the urinary bladder is a multistep process, opens many potentially important areas of research which in the future may provide information on which the prevention of bladder cancer can be based. Worthy research objectives relate to the development of a rapid test for bladder carcinogenesis based on markers of preneoplastic lesions, further improvements in methods for identifying known bladder carcinogens and their metabolites in urine, and further development of methods of testing in the urine or other body fluids for metabolites which have been related to bladder cardinogenesis.

The new information from laboratory studies as to the carcinogens involved in the etiology of bladder cancer has increased the need for epidemologic studies on various population groups. In many instances, relating epidemiologic results to laboratory results increases the understanding of each. In the rapidly developing area of bladder carcinogenesis, the formats of some of the epidemiology studies include several case-control studies in which populations having high incidence of bladder cancer are compared with populations having low incidence of this disease.

It is important to determine the role of seeding from primary tumors in the reestablishment of superficial carcinoma away from the site of the primary tumor. The role of cytology in the proper management of spreading superficial carcinoma of the bladder is so essential that continued efforts are being made to develop automated procedures for the identification of populations of cancer cells shed in the urine. Attempts to isolate a tumor-associated antigen from cancer cells shed in the urine of bladder cancer patients has been encouraging. This would be a useful indicator of cancer, and support of this area is continuing.

At present, transurethral resection is suitable for removing small to moderate-sized, localized, superficial cancer lesions. When superficial lesions are numerous or large, this form of surgery is inadequate and cystectomy is carried out. There is a need to develop an intravesical or systemic treatment less destructive than cystectomy. Results to date with the drug thioTEPA injected into the bladder are encouraging, and other chemotherapeutic agents such as mitomycin are available and are being tried.

Carcinoma of the prostate is the second most common site of cancer in men, accounting for 17 percent of malignant tumors occurring in U.S. males. The prostate cancer-related death rate (15 deaths annually for every 100,000 U.S. males) has not changed significantly over the past thirty years. In 1979 an estimated 64,000 new cases of prostatic cancer were diagnosed and over 21,000 deaths of American men are expected from this disease. In spite of these figures, prostate cancer has been the subject of only limited clinical and laboratory research through the early 1970's. In response to the need for a comprehensive and coordinated research effort, the National Prostatic Cancer Project (NPCP) was activated in 1973, with headquarters at Roswell Park Memorial Institute, in accordance with the objectives of the National Organ Site Program. The Project has developed a research program that encompasses the areas of Etiology and Prevention, Detection and Diagnosis, and Treatment of prostatic cancer. The pursuit of targeted research through investigator-initiated efforts has resulted in application of a broad spectrum of experimental research disciplines to prostate cancer, as well as the development and evaluation of single and combination therapy modalities for local, regional, and metastatic disease.

The focal point toward which the efforts of the National Prostatic Cancer Project are directed is the prevention and improved treatment of prostatic cancer. This objective is complemented by immediate Project endeavors aimed at decreasing morbidity and increasing survival time of prostate cancer victims.

The widespread use of endocrine therapy for prostatic carcinoma dates back to its first introduction in the early 1940's and continues to result in objective and subjective responses in the majority of patients. However, since hormonal therapy was unable to cure metastatic disease, the desirability of studying drugs which may affect this type of cancer was recognized and led to the July 1973 initiation of the Cooperative Clinical Trials Program of the National Prostatic Cancer Project. This was the first national clinical cooperative program on chemotherapy of prostate cancer with criteria of patient randomization and clinical response tailored to the biological characteristics, metastatic behavior, and age of patients with this disease. Beginning with randomized studies of the effects of single chemotherapeutic agents on patients who fail to respond or no longer respond to conventional treatment, the program has expanded to include clinical trials using both single agents and combinations of agents aimed at patients with metastatic disease who are stable after previous treatment or who are previously untreated. Trials have also been initiated to determine the efficacy of chemotherapy as adjuvants to surgery or definitive radiotherapy in patients with earlier stages of the disease. Finally, the National Prostatic Cancer Project supports efforts in the treatment category that are directed towards the synthesis of compounds with specific prostate cytotoxicity. Agents with potential activity are screened in animal, cell, and organ culture test systems, which are useful in selection of those chemotherapeutic agents for use in Phase I and II trials.

In the detection and diagnosis category, a major effort continues to be directed at developing and testing specific and sensitive immunochemical assays for prostatic acid prosphatase as diagnostic tools. Identification and development of other potentially useful biological markers are being tested. This work is supported by tissue and serum repositories which provide investigators ready access to cell cultures, tissue samples, and sera samples from men with normal, benign hypertrophic, and carcinomatous prostates.

The search for factors associated with prostate cancer and a better understanding of the nature and history of the disease continues. Ongoing and new projects in the Etiology and Prevention category are directed at further characterization of established animal tumor models and development of new animal models. Complementing these model systems are organ and cell culture studies of human prostate tissue. The relating of prostatic carcinoma specific antigens to immune mechanisms continues. To date, virologic studies of prostate cancer have shown that viral particles do not play a significant oncogenic role in human prostate cancer. Models of prostate cancer are being studied extensively for risk factors associated with the development of the disease, and epidemiologic studies are probing the relation of genealogic dietary, occupational, socioeconomic, sexual, and medical factors to human prostate cancer.

DIVISION OF CANCER TREATMENT

The Division of Cancer Treatment sponsors research which encompasses all aspects of the treatment of cancer. The majority of the research protocols include patients across the age spectrum and patients over age 65 are not separated for special treatment. However, in selected situations patients over age 65 have been the focus of a specific research interest and these will be discussed.

The investigators in the Eastern Cooperative Oncology Group have addressed the question of whether elderly patients experience more frequent or more severe side effects from anti-cancer treatment. They compared patients under age 65 with patients over age 65 who had received the same chemotherapy program. Older patients did not experience more frequent or more severe side effects compared with younger patients. This observation supports the philosophy of including patients in treatment protocols without regard to age if they satisfy other criteria for receiving the specific treatment.

In some diseases patients over age 65 have a poorer prognosis than younger patients. As an example, the Brain Tumor Study Group has documented that patients with malignant brain tumors who are over age 65 have a shorter survival than younger patients. The group has noted improvement in survival with administration of radiation therapy and chemotherapy, but the negative effects of age persist even in the improved results. This is receiving continuing attention by this group.

In a few diseases, older patients may respond differently to therapy than younger patients. An example is breast cancer where older patients have a more favorable response to hormone therapy than do younger patients. Three studies currently in progress demonstrate efforts to capitalize on this principle.

The Eastern Cooperative Oncology Group (ECOG) activated protocol 1178 in April of 1978. It is a randomized study comparing the antiestrogen, tamoxifen, to placebo in the surgical adjuvant therapy of patients with lymph node positive breast cancer who are 65 years of age or older. As of July 1981, a total of 165 patients had been entered on this study, 139 of them evaluable at the time of the update. So far, only 13 patients have relapsed. The study has not been followed long enough to permit conclusions. The Group continues to enter patients into the study.

Dr. Gianni Bonadona in Milan, Italy, under contract with the Division of Cancer Treatment, is conducting a study in women over age 65 who have undergone mastectomy for breast cancer and who have involved axillary lymph nodes. The randomized trial compares combination chemotherapy consisting of cyclophosphamide, methotrexate, and 5-fluorouracil (CMF) with CMF plus the antiestrogen tamoxifen. The study is continuing to accrue patients. Again, the followup is too short to allow meaningful analysis of treatment results.

The Carcinogenesis Extramural Program has awarded grants concerned with the nutritional and metabolic changes responsible for the increased tumor incidence which occurs in advanced age. Studies conducted in animals assess dietary influence on survival patterns and mortality rates and analyze the mechanisms by which long term dietary restriction decreases tumor incidence and growth.

The Field Studies and Statistics Program supports epidemiologic research designated to generate and test ideas concerning the origins of cancer by studying environmental and genetic factors that contribute to the occurrence of the disease. Studies attempt to identify groups of persons at high risk of cancer and test hypotheses that relate to specific risk factors. Data are collected and analyzed on cancer incidence by geographic location, race, age, economic status and occupation. These studies are not primarily geared toward aging; however, they have shown that the incidence of cancer rises sharply with age. Analysis is made of age curves for the various cancer sites to provide precise information on how the risk of cancer varies with advancing age. The Surveillance, Epidemiology and End Results Program (SEER), covering approximately 10% of the U.S. population has produced data that shows more than one-half of the cancers occur among persons 65 years of age and older.

Through case-control and cohort studies the Field Studies and Statistics Program attempts to determine what age groups are especially vulnerable to carcinogenic hazards, including chemical agents and ionizing radiation and gain a better understanding of the mechanism involved in carcinogenesis and how the aging process may increase the risk of cancer to those exposed to known carcinogens. To clarify the mechanisms responsible for the link between cancer and aging, the Program conducts studies of population groups with conspicuous defects that may be more subtly associated with the aging process.

DIVISION OF CANCER CAUSE AND PREVENTION

Cancer is a disease which increases in frequency with aging and appears to share characteristics associated with the process of aging, i.e., modifications of cell regulation. Studies of basic mechanisms involved in the carcinogenic process conducted by the Laboratories of the Carcinogenesis Intramural Program can be expected to provide insight into the aging process, and to lead to better approaches toward prevention of tumors, particularly those which affect the aged.

The Laboratory of Cellular and Molecular Biology conducts research on tumors found predominantly in older age groups. The major research goals of this Laboratory are to determine the etiology of naturally occurring cancers, to elucidate mechanisms of transformation by carcinogenic agents and environmental influences, and to develop strategies capable of preventing natural and induced cancers.

The Laboratory of Viral Carcinogenesis performs studies which produce significant by-prdouct data applicable to studies on aging and indirectly to the diagnosis, prevention, and treatment of cancer which, by its nature, eventually affects the elderly population. For example, the examination of the genetic control of information related to oncogenic retroviruses found in the DNA of primates, including man, is leading to greater understanding concerning the etiology of certain cancers, the susceptibility or resistance of hosts to the progression of cancer, and ultimately to the manner in which nonmalignant alterations in cellular physiology affect the status of the aging host.

Current studies in the Laboratory of Experimental Pathology investigate the synergistic effects of chemical carcinogens and their role in the induction of neoplastic transformation. The Laboratory of Comparative Carcinogenesis is conducting studies on the development of cancer in association with age-related preneoplastic lesions in animals and humans and on chemoprevention of prostate cancer in an animal model of latent carcinoma. Aging ACI rats, with a high incidence of latent prostatic cancer and preneopalstic lesions and future clinical cancer, are being fed diets containing one of three retinoids to determine the effect of the development of prostatic cancer. The Laboratory of Biology is concerned primarily with modulation of the process leading to malignancy. The ability to induce neoplastic transformation is being correlated with the age of the cell culture and uses normal cells derived from individuals of different ages.

Research in the Laboratory of Molecular Carcinogenesis has been concerned primarily with studies of escape from aging or the senescence phenomena in neoplastic cells. One important characteristic of tumor cells is their continuous and unlimited growth, i.e., escape from senescence. All normal human diploid cells show a limited life span or a limited number of cell generations when propagated in culture. This phenomena is called senescence or aging of the cells and is considered analogous to the aging of individuals. This Laboratory has also studied cells of patients who have genetic diseases characterized by abnormal, accelerated aging and a higher incidence of cancer.

The Carcinogenesis Extramural Program has awarded grants concerned with the nutritional and metabolic changes responsible for the increased tumor incidence which occurs in advanced age. Studies conducted in animals assess dietary influence on survival patterns and mortality rates and analyze the mechanisms by which long term dietary restriction decreases tumor incidence and growth.

The Field Studies and Statistics Program supports epidemiologic research designated to generate and test ideas concerning the origins of cancer by studying environmental and genetic factors that contribute to the ocurrence of the disease. Studies attempt to identify groups of persons at high risk of cancer and test hypotheses that relate to specific risk factors. Data are collected and analyzed on cancer incidence by geographic location, race, age, economic status and occupation. These studies are not primarly geared toward aging; however, they have shown that the incidence of cancer rises sharply with age. Analysis is made of age curves for the various cancer sites to provide precise information on how the risk of cancer varies with advancing age. The Surveillance, Epidemiology and End Results Program (SEER), covering approximately 10 percent of the United States population has produced data that shows more than one-half of the cancers occur among persons 65 years of age and older.

Through case-control and cohort studies the Field Studies and Statistics Program attempts to determine what age groups are especially vulnerable to carcinogenic hazards, including chemical agents and ionizing radiation and gain a better understanding of the mechanism involved in carcinogenesis and how the aging process may increase the risk of cancer to those exposed to known carcinogens. To clarify the mechanisms responsible for the link between cancer and aging, the Program conducts studies of population groups with conspicuous defects that may be more subtly associated with the aging process.

NATIONAL CENTER FOR HEALTH STATISTICS

GOALS AND OBJECTIVES

The National Center for Health Statistics collects, analyzes, and disseminates national health statistics on vital events and health activities, including health status, morbidity, health resources, and health costs. Although the Center does not operate collection or analytical programs devoted to aging *per se*, the Center does collect and analyze data on aging as part of its broader responsibility to produce statistics on the Nation's health.

The Center collects health data about the entire population, regardless of age, and disseminates it through public-use data tapes (where the age of each subject is available) and reports in the Vital and Health Statistics series (where the category "age 65 and over" is presented at the minimum). The goals of the Center's analytical efforts are varied, ranging from general description, to generating hypotheses for future study, to testing of specific hypotheses. In view of the Center's role as the government's principal general-purpose health statistics organization, the majority of its reports fall into the general description category atlhough some in-depth analyses are conducted. Most of the Center's collection and analysis activities include the elderly as one segment of the Nation's population. Analyses which focus solely on the elderly or on health problems most prevalent among the elderly (e.g., stroke, osteoporosis) are conducted on an ad hoc basis.

PROGRAM ACTIVITIES

The Center's 1981 program activities specifically related to aging include data collection and analysis as described below.

DATA COLLECTION: NHANES I EPIDEMIOLOGIC FOLLOWUP SURVEY

The objective of the NHANES I Epidemiologic Followup Survey is to obtain longitudinal data on the health of a nationwide sample of persons aged 33 and over. The data will be collected on a sample of 14,000 examinees who were aged 25–74 when they were respondents to the National Health and Nutrition Examination Survey (NHANES) conducted by the Center during 1971–74. The Epidemiologic Followup Survey will focus on how factors previously measured in the earlier survey (through extensive physical examination) relate to health conditions that have developed since that time. Information concerning those members of the original survey population who died will be obtained by using the National Death Index. Data available from the Survey can be used to analyze long-term outcomes of environment and personal health practices on health status and use of health services.

The Followup Survey is being funded by the National Institute on Aging (with additional support from other Institutes of the National Institutes of Health) and by the Alcohol, Drug Abuse and Mental Health Administration. Activities in fiscal year 1981 consisted of developing the questionnaires and procedures for data collection and for tracing the original survey population based on addresses obtained at the time of the 1971–74 NHANES I Survey. The pretest and national data collection for the Epidemiologic Followup Survey will be conducted in 1982; public-use data tapes should be available in late 1984.

ANALYSIS (COMPLETED): CHANGE IN MORTALITY AMONG THE ELDERLY, UNITED STATES: 1940–78

The objective of this activity is to analyze changes in mortality among the elderly by examining age- and sex-specific death rates over the period 1940–78 and cause-specific rates from 1950–78. This report marks the first time that national mortality rates for the elderly have been analyzed and published in such great detail. A summary of this analysis is included in a chapter of the 1981 edition of the Center's annual report to Congress, Health, United States.

ANALYSIS (COMPLETED): CHARACTERISTICS OF NURSING HOME RESIDENTS, HEALTH STATUS, AND CARE RECEIVED

The objective of this activity is to describe the utilization and health status characteristics of nursing home residents in 1977 by major demographic characteristics, such as age, sex, and race or ethnicity. The data are examined from two perspectives: the health status of the resident and service characteristics of the facility.

ANALYSIS (COMPLETED): DISCHARGES FROM NURSING HOMES

The objective of this activity is to describe the characteristics of persons discharged from nursing homes during 1976. This report marks the first time that national data on completed episodes of care in nursing homes are available. Data are presented in terms of discharge status (live or dead) and duration of stay, according to demographic characteristics, health status, health services received, and primary source of payment.

ANALYSIS (COMPLETED): HEALTH CHARACTERISTICS OF PERSONS WITH CHRONIC ACTIVITY LIMITATIONS

The objective of this activity is to describe the demographic and health characteristics of noninstitutionalized persons with chronic activity limitations. It is based on data from the 1977 National Health Intreview Survey.

ANALYSIS (COMPLETED): STATE VARIATION IN LONG-TERM CARE FOR THE ELDERLY

The objective of this activity is to describe the living arrangements and demographic and health characteristics of the elderly living in the community in five States and compare this information to nursing home utilization rates. This analysis is a chapter in the Center's 1981 report to Congress, Health, United States.

ANALYSIS (COMPLETED): STROKE SURVIVORS AMONG THE NONINSTITUTIONALIZED POPULATION 20 YEARS OF AGE AND OVER

The general objective of this activity is to present a brief description of the prevalence of stroke in the United States based on data from the 1977 National Health Interview Survey. The analysis describes persons who have had stroke-related symptoms and examines the relationship between selected chronic conditions and stroke.

ANALYSIS (COMPLETED): USE OF HEALTH SERVICES BY WOMEN 65 YEARS OF AGE AND OVER

The objective of this activity is to describe the use of office-based physicians, short-stay hospitals, and nursing homes by elderly women. Patterns of use are analyzed by demographic characteristics and condition of the patients, services provided, and outcome.

ANALYSIS (IN PROGRESS): BASIC ANALYSIS OF COUNTY DATA ON MORTALITY RATES FOR STROKE AND HEART DISEASE

The objective of this activity is to analyze data at the county level on the mortality rates of stroke and heart disease to determine whether the decline in mortality rates for stroke is a decline in actual prevalence or merely in case fatality.

ANALYSIS (IN PROGRESS): RELATIONSHIP BETWEEN FLUORIDE AND OSTEOPOROSIS USING DATA FROM TWO NATIONAL PROBABILITY SURVEYS

The objective of this activity is to examine the hypothesis that fluoridated water protects against osteoporosis by analyzing national data on persons 40 years of age and over from the National Health Interview Survey and the NHANES.

EXPENDITURES

Expenditures for the NHANES I Epidemiologic Followup Survey in Fiscal Year 1981 were approximately $950,000. Total cost of the entire data collection effort is estimated at $4.2 million.

Expenditures for the staff time to conduct the analyses described above were approximately $134,000 in fiscal year 1981.

NATIONAL EYE INSTITUTE

I. AGENCYWIDE MISSION, GOALS, AND/OR OBJECTIVES

The National Eye Institute (NEI) supports and conducts basic and clinical research on the causes, diagnosis, and treatment of blinding and disabling eye disorders. New knowledge about the normal and abnormal structures and functions of the eye and visual system is essential to understanding the causes of blindness and other visual impairments and disabilities and improving their prevention, diagnosis, and treatment. Ocular disorders which are common in the elderly and which are actively being researched by NEI-supported scientists include senile macular degeneration, cataract, diabetic retinopathy, and glaucoma.

II. NEI Aging-Related Research by Program

A. RETINAL AND CHOROIDAL DISEASES PROGRAM—MACULAR DEGENERATION SUBPROGRAM

1. *Objectives*

Macular degeneration associated with aging accounts for approximately 13 percent of all new cases of blindness occurring annually. Diseases of the macula affect the central, high visual acuity area of the retina. The primary objectives of the Macular Degeneration subprogram are to: (1) determine the causes of this common and serious disorder; (2) understand the anatomical, physiological, biochemical, and nutritive interrelationships among the retina, the choroid, and other eye tissues in both the normal and abnormal state; (3) improve the diagnosis and treatment of the various forms of macular disease.

2. *Current and Planned Activities*

(a) Major activities (fiscal year 1981) have included:

Macular photocoagulation study.—The objective of this clinical trial is to determine whether the use of argon laser photocoagulation to obliterate new blood vessels that develop outside the foveal region is of value in preventing permanent loss of central visual function in patients with senile macular degeneration (SMD). Approximately 600 patients with SMD will be followed for up to five years. This research is being done at 12 clinics located around the United States. If laser treatment of SMD proves successful this would mean that the retirement years of millions of Americans might not be hampered by the inability to read or move about unaided.

Because it is not possible to obtain diseased human retinal tissue by biopsy for anatomic, physiologic, and biochemical studies, the development of animal models for macular degeneration would provide new routes of investigation. An experimental model of maculopathy using nonhuman primates is being developed.

To understand the pathological changes which take place in SMD, clinicopathological studies of age-related changes in the neural retina, retinal pigment epithelium, and choroid are needed. One NEI grantee has access to over 100 aging rhesus monkeys which are providing a unique opportunity to study the early changes in SMD. The results of studying the visual function of these animals while they are alive will be correlated with histologic and electron microscopic observations of the retina after death.

(b) Major planned activities (fiscal year 1982 and beyond) include:

Efforts to develop a reliable animal model of SMD will be continued. In addition, attempts will be made to study, using the most advanced biochemical and physiological techniques, the effects of aging on the retina and choroid, especially how aging causes new abnormal blood vessels to form. Because attempts at growing retinal cells in culture are increasingly successful, biological studies of the pigmented epithelial cells appear more promising.

3. *Major Progress Highlights*

Initiation of the Macular Photocoagulation Study and the *recruitment* of eligible patients for participation in the study.

Longitudinal studies of the clinical, histological and visual acuity changes in the macula of a large colony of monkeys.

B. CATARACT PROGRAM—SENILE CATARACT SUBPROGRAM

1. *Objectives*

Senile cataract is the opacification of the human lens that occurs with aging. The major objectives of this subprogram are (1) to determine the cause(s) and pathogenesis of senile cataract including its risk factors, and (2) to seek means to prevent, delay the progress of, or reverse the cataractous process.

2. *Current and Planned Activities*

(a) Major current activities (fiscal year 1981) have included:

Cooperative Cataract Research Group.—The CCRG is a consortium of 21 cataract research groups that has been formed to facilitate human senile cataract studies by a uniform classification system, a computerized data base accessible to all participants, and broadly available lens samples.

Extramural research support (major topics):

—Biochemical studies of the progressive decrease in soluble proteins with age in the normal human lens.

—Role of the plasma membrane cytoskeleton in the cataractous process.

—Role of oxidants formed in vivo, such as superoxide anions, hydrogen peroxide, lipid peroxides and hydroperoxides, singlet oxygen, and hydroxyl radicals.

—Association between the prevalence of cataract in human populations and high levels of ultraviolet radiation and sunlight.

(b) Major planned activities (fiscal year 1982 and beyond) include:

The NEI will increase its support of basic and clinical research on the relationship of senile cataract and systemic aging in both its intramural and extramural programs. Topics to receive the highest priority for funding include the following:

—Study of the natural history of the cataractous process and of risk factors.

—Further study of the molecular architecture, biochemical composition, function and fate of the plasma membrane of normal and cataractous human lens fiber cells, and of the interaction between the plasma membrane and the cytoskeletal and soluble lens proteins.

—Composition and three-dimensional organization of the fiber cell cytoskeleton.

—Characterization of the light scattering entities of the cataractous lens using noninvasive techniques.

—Study of the antioxidant defense mechanisms of the lens, including relevant enzyme kinetics.

—Role of environmental factors such as ultraviolet light and nutrients.

—Development of an in vitro culture system for the human lens.

—Systems for better classifying cataractous lenses.

3. Major Progress Highlights

The establishment of the Cooperative Cataract Research Group has stimulated collaborative research on senile cataract and greatly facilitated studies on the human lens. Improved systems for classification of lens opacities developed by the CCRG have permitted a more accurate correlation between specific kinds of cataract and their structural and chemical characteristics.

The development of a slit-lamp camera densitometric apparatus is a major advance in cataract research. This instrument allows the clinician and scientist to localize the lens opactity accurately in vivo, determine its dimensions, and follow the progress of the cataract over time.

Identification of a progressive decrease in soluble protein and in increase in the amount of insoluble protein with aging of the normal human lens.

Induction of cataracts by exposing animals to ultraviolet light and demonstration that sunlight causes a yellowing of the human lens in the presence of added tryptophan.

C. CATARACT PROGRAM—DIABETIC AND METABOLIC CATARACT SUBPROGRAM

1. Objectives

The overall objectives of research in diabetic and metabolic cataracts are to understand and identify the factors involved in the development of these cataracts and devise means of delaying and preventing their formation. Specific objectives of this subprogram include the following:

—To develop effective drugs which will slow or block the development of diabetic cataracts in humans.

—To evaluate the safety and efficacy of drugs used in delaying or preventing diabetic cataracts.

—To establish cell lines in tissue culture from cataracts of different etiology.

—To elucidate further that diabetes can hasten the development of senile cataracts.

—To establish the role of nutrition in human senile cataracts through epidemiological studies.

—To develop additional animal models in the study of diabetic and metabolic cataracts.

2. Current and Planned Activities

(a) Major current activities (fiscal year 1981) have included:

Support of intramural and extramural research on sugar cataracts either produced experimentally or in some animal models with congenital diabetes.

Assessment of the importance of aldose reductase and development and evaluation of the efficiency of aldose reductase inhibitors in delaying sugar cataracts.

(b) Major planned activities (fiscal year 1982 and beyond) include:

Studies of enzymology, blood chemistry, lens swelling, toxicology, and biochemistry will be extended and intensified to define further the etiology and pathogenesis of diabetic and metabolic cataract. These studies will involve cellular and animal models. Epidemiologic studies and efforts to improve diagnosis, treatment, and management will be initiated.

3. Major Progress Highlights

Cell lines from different types of cataractous lenses have been established by means of tissue culture techniques. Such an approach will permit biochemical characterization of the disease process not only in animal models but in human genetic cataracts which are infrequently available for laboratory study.

Two recent studies showed a marked excessive prevalence of senile cataracts occurring in diabetics compared to nondiabetics up to age 64. In persons under age 65, the prevalence was three to four times higher among diabetics than nondiabetics.

A large number and variety of aldose reductase inhibitors have been shown to be effective in retarding cataract formation in diabetic and galactosemic rats.

In human lenses, increased levels of sorbitol have been correlated with increased blood sugar levels.

The onset of cataracts in streptozotocin-induced diabetic rats has been indefinitely delayed upon treatment with a powerful aldose reductase inhibitor.

NATIONAL HEART, LUNG, AND BLOOD INSTITUTE

In fiscal year 1981, the NHLBI supported 27 projects directly related to aging at a funding level of $2,027,731. The NHLBI continues to support a very large program of research in arteriosclerosis, a significant problem among the aging population. In fiscal year 1981, this program included 358 projects at a total funding level of $98,518,140.

NHLBI PROGRAMS ON AGING

Project No.	Project title	Fiscal year 1981 amount
1 R01 HL23913-02	Systolic hypertension in the elderly (Human)	$317,537
1 R01 HL23917-02	do	106,589
1 R01 HL23919-02	do	558,284
1 R01-HL23919-01A1S1	do	88,074
1 R01 HL23914-02	do	[1] 253,500
1 R01 HL23916-02	do	[1] 322,472
1 R01 HL23924-02	do	[1] 288,888
5 R01 HL06736-20S1	Biogenic-mechanical factors in microcirculation (rats, gerbils)	24,521
5 R01 HL18284-07	Aging erythrocytes—bio-recognition and elimination (monkeys)	70,617
2 R01 HL8629-07	Influence of aging and hypertension on the myocardium (rats)	55,945
5 R01 HL23358-02	Age related changes in cardiac autonomic interactions (dogs, rabbits, mice).	140,719
5 R01 HL24138-03	Prostaglandin synthesis and function in adult cardiac cells (rats)	48,262
5 H01 HL25399-03	Cerebrovascular changes in age and hypertension (rats)	79,958
5 R01 HL25408-03	Plasma activators of human pancreatic proelastase 2 (dogs)	38,218
1 R01 HL25786-02	Quality of life and health status of former athletes	45,353
2 R01 HL9858-06	UMMC-blood pressure-precursors and consequences	17,484
3 R01 HL24369-02	Effect of dietary modification on blood pressure control	73,527
3 R01 HL24998-01	Control of hypertension by nonpharmacologic means	524
5 R01 HL24998-02	do	9,354
3 R01 HL24999-01	do	1,299
5 R01 HL24999-02	do	10,997
1 R01 HL25876-01	24-hr blood pressure in adolescents	11,291
1 R01 HL26235-01	Type A behavior pattern: CHD and Non-CHD outcomes	6,350
1 K04 HL00853-01	Cardiac electrophysiology and adrenergic receptors	4,106
1 R01 HL24423-01	Alcohol and other risk factors for myocardial infarction	21,951
1 N01 HV12910-00	Study records related to arteriosclerosis	28,213
1 N01 HV12911-00	do	19,081
3 R01 HL25523-01	Community prevention program for cardiovascular diseases	350
5 R01 HL25523-02	do	140,314
1 P50 HL25451-01, Subproject 0009.	Hypertension specialized center of research; mechanisms of systolic hypertension in elderly people.	71,538
5 R01 HL23385-03	Excercise intervention in older men—10-yr followup	37,275
Total		2,027,731

---

[1] Funded by the National Institute on Aging.

NATIONAL INSTITUTE OF NEUROLOGICAL AND COMMUNICATIVE DISORDERS AND STROKE

I. Agencywide Mission, Goals and/or Objectives

The mission of the National Institute of Neurological and Communicative Disorders and Stroke (NINCDS) is to conduct and support research and research training on the causes, prevention, diagnosis, and treatment of neurological and communicative disorders and stroke. Many of the disorders of aging are a consequence of the degeneration of the nervous system. The NINCDS supports research on Alzheimer's disease, senile dementia, and other dementias of aging. The major research effort is to define etiology and pathogenesis and provide a scientific base for programs of prevention. The Institute conducts clinical research projects assaying neurotransmitters and their metabolites; therapeutic trials of promising pharmacologic agents; epidemiologic studies of well-defined populations to determine prevalence, incidence, and associated risk factors; investigation of the role of "slow viruses" in chronic dementias by development of in vitro methods of diagnosis and major epidemiologic studies to determine a possible viral etiology. The NINCDS supports: research in neurochemistry, neural membranes, neurotransmitters and the putative role of slow viruses; with the National Institute of Mental Health, two tissue banks provide an adequate supply of Alzheimer's tissue for future research; research training; and has initiated the National Institutes of Health Program on Positron Emission Tomography (PETT) scanning, a new in vivo method to study brain metabolism in man.

II. Agency Activities by Program Area

A. NEUROLOGICAL DISORDERS PROGRAM

1. Objectives

The mission of the Neurological Disorders Program (NDP) is to promote and support research in six areas: disorders of early life, disorders of adult life, demyelinating and sclerosing disorders, convulsive and paroxysmal disorders, neuromuscular disorders, and infectious diseases. The major portion of the research on aging falls within the area of disorders of adult life. This subprogram is presently called the Neurological Disorders of Aging and is composed of five sections: Parkinson's disease, Huntington's disease, Alzheimer's disease and other disorders of aging, General Studies, and Related Disorders. In Parkinson's disease there is a strong emphasis on pharmacological experimentation. Many of the grants on Parkinson's disease focus on the biochemistry of the illness and the ways in which neurotransmitter system transit messages in the brain areas most affected.

Congress established a Commission for the Control of Huntington's Disease and Its Consequences whose report in 1977 outlined major recommendations for research, care, and treatment of Huntington's disease patients and families. The Commission emphasized the need for expanded basic and clinical research in genetics and neurobiology, as did the NINCDS Panel on inflammatory, Degenerative, and Demyelinating Diseases and voluntary public health organizations participating in the present planning effort. Specific NINCDS research activities in Huntington's disease include biochemical and pharmacological studies focused on specific transmitters, enzymes, and enzyme deactivators in the brain and in peripheral tissues; genetic studies; exploration of membrane alterations in red blood cells; and investigation of the immune response which has produced some evidence of a viral or autoimmune process.

Specific research activities in Alzheimer's disease and related disorders include histochemical, ultrastructural, immunological, and biophysical investigations of the pathological changes in neurofilament proteins (including the neurofibrillary tangles characteristic of Alzheimer's disease) and investigation of the effects of trace metals, such as aluminum, and environmental toxins in the etiology of Alzheimer's disease.

General studies are also being pursued on brain changes with age, including altered membrane transport, the development and composition of senile plaques, the biochemistry and histology of the aging brain, and immunological changes dependent on the aging process. Several studies are exploring changes in neuroendocrine function and behavior with age; studies continue on long-term memory and age effects.

2. *Current and Planned Activities*

a. Major current activities

NINCDS has awarded a contract for the development of a Huntington's Roster to the University of Indiana. The Roster can match together family members with different names and from disparate states, thus creating much larger pedigrees. Investigators also have need for different types of research subjects. The Roster can select families needed for particular research projects and serve as an intermediary between the scientist and the subject.

During the past year two grants were awarded to establish "Centers Without Walls." Each Center supports clinical and basic research aimed at uncovering the etiology and pathogenesis of Huntington's disease and developing new physiological and sociopsychological treatments for the disorder.

The NDP continues to issue Program Announcements on Research Grants related to movement disorders and Alzheimer's Disease.

b. Major planned activities

A unique concentration of Huntington's disease families live in small villages surrounding Lake Maracaibo in Venezuela. The NINCDS will continue to work with investigators at the University of Zulia to study these families. In response to the Secretary's DHHS initiative, a Program Announcement requesting research grants in Alzheimer's Disease and the Dementias of Aging will be issued jointly with the National Institute on Aging (NIA).

3. *Major Program Highlights*

Two apomorphine derived drugs have shown definite promise as clinically useful anti-Parkinsonian agents.

Investigators sponsored by NINCDS have pharmacological evidence of three types of dopamine receptors in the brain.

A contract for the establishment of a Huntington's Disease Roster was awarded to the University of Indiana.

Two grants were awarded to establish "Centers Without Walls" as recommended by the Congressionally mandated Commission for the Control of Huntington's Disease and its Consequences.

A large research project on "Senile Dementia: Alzheimer and Vascular Disorders" was partially funded by NINCDS and partially by NIA.

In Alzheimer's patients, one NINCDS grantee, has shown no major decrement of cortical neurons occurs relative to age-matched controls, but that a 75–90 percent loss of cortical choline acetyltransferase is seen in these patients. Another NINCDS grantee has recently shown a specific degeneration of the neurons comprising the nucleus basalis of Meynert.

B. INTRAMURAL RESEARCH PROGRAM

The NINCDS Intramural Research Program (IRP) conducts basic and clinical research in neurological and communicative disorders and relevant disciplines. This program comprises some 17 laboratories and branches, with some 140 projects currently under way.

1. *Objectives*

The IRP is currently conducting several projects directly related to aging research. One involves a longitudinal, prospective study of dementia on Guam, while the rest are located on the NIH campus.

2. *Current and Planned Activities*

In the Guam study an attempt will be made to correlate age-disease associated changes in specific cognitive and motor functions with selected neuropathologic and biochemical indices of neuronal damage. During a three-year period approximately 2000 native born Guamanians are being randomly selected for study. Medical, neurologic, clinical chemistry, and electroencephalographic examinations together with a specially designed psychological test battery are being applied to each patient on admission to the study and thereafter at three-year intervals. In addition, some individuals may receive a CAT scan of the head. This investigation addresses not only the specific disease of Guamanian parkinsonian type of dementia, but also all other types of dementing illnesses which occur in an aging population. An autopsy, in addition to routine neuropathologic evaluation, all brains will receive detailed morphometric studies (to include regional cell and lesion counts), special cell and tract degeneration studies (using the Golgi and Marchi techniques), virologic and immunologic evaluations (Gajdusek, et al.), electron probe and neutron capture analysis for heavy metal accumulations, neurofibrous protein characterization, and regional transmmitter synthesizing enzyme activities and receptor binding affinities.

In Bethesda, IRP is currently conducting radiologic, biochemical, pharmacologic and virologic studies of Alzheimer's disease and related dementing disorders. The PETT research involves use of the 18-fluorodeoxyglucose method to search for localized areas of neuronal dysfunction, in the hope of focusing future biochemical probes of pathogenetic mechanisms. These studies are carried out under basal conditions and during psychological and pharmacologic activation procedures. Biochemical studies currently involve attempts to link specific aspects of cognitive function with alterations in lumbar spinal fluid levels of particular transmitter substances including monoamines (by means of the oxygen-18 turnover method), vasopressin, and vasoactive intestinal peptide. Pharmacologic trials of various drugs are currently being conducted including arecoline (a potent muscarinic agonist), and two vasopressin derivatives (lysine vasopressin and desglycinamide arginine vasopressin). Finally, attempts to isolate a transmissible agent in patients with Alzheimer's disease continue.

3. Major Progress Highlights

An NINCDS sponsored Workshop on Dementia and the subsequent multidisciplinary study of Dementia on Guam.

A PETT research laboratory has become fully functional.

C. COMMUNICATIVE DISORDERS PROGRAM, NINCDS

1. Objectives

The objectives of the Communicative Disorders Program are to determine the effects of aging on functions by which human beings communicate with each other (speech, language and hearing) or with their environment (balance, taste and smell). The objectives with regard to the effects of aging on hearing include improvement of diagnostic procedures to identify presbycusis (hearing impairment due to aging) and differentiate it from impairments due to noise exposure and ototoxic drugs; improvement of treatment and management of hearing loss in the aged; and, increased understanding of the aging process in the auditory system.

The objectives with regard to the effects of aging on speech and language include: the determination of how speech production, speech perception and language encoding and decoding functions are affected by the aging process; the determination of the relationship between aging effects on verbal memory, and word retrieval and speech comprehension deficits in aging; and, the effects of aging on the motor skills involved in speech production, and how such changes affect speech intelligibility, fluency and phonatory control.

2. Current and Planned Activities

Several laboratories are currently investigating temporal bones of aged humans and monkeys; research in the speech perception ability of older adults with and without wearing a hearing aid; and, auditory evoked potentials in older individuals to document changes in the brainstem that may be related to aging of that portion of the auditory mechanism.

Psycholinguistic studies are ongoing to examine word retrieval deficits on a naming test in various forms of dementia and to determine how these deficits differ from errors made by aphasic adults and normally aging adults.

Speech production changes associated with aging are being contrasted with those found in neurological diseases to determine the similarities and dissimilarities between aging and disorders of the basal ganglia.

Planned activities addressing the hearing problems of the aging population include the determination of which individuals will use a hearing aid successfully; the development of "intelligent" hearing aids that can be programmed for each individual; encouragement of basic research into the phenomenon of tinnitus (ringing in the ears which often accompanies hearing loss in aging); and, continued support of research to document changes in the auditory system due to aging.

Planned activities addressing the speech and language disorders of the aged include: studies of the breakdown of discourse in the aged and determination of the psycholinguistic functions contributing to such disturbances; and, comparisons of the precise timing of the various speech articulators between younger and older speakers to identify how speech motor control is affected by aging.

3. Major Progress Highlights

Studies of people over 60 years show that if a significant impairment of hearing has not occurred by 65, people are less likely to incur such a loss after that age.

Older animals (white carneau pigeon) show significant correlation between hyptertension and the loss of inner ear AC cochlear potentials.

Documentation of extent of cochlear degeneration due to aging to determine the feasibility of cochlear implants for aging persons.

Determination that semantic processes in language encoding and decoding are disturbed in aging while syntactic processes remain relatively intact.

Determination that communicative skill decreases to a significant degree in normally aging adutls past the age of 65.

Determination that severity of aphasia (language) impairment following stroke increases with increased age at the time of the stroke. The detrimental effects of aging on aphasia rehabilitation are greatest in institutionalized populations.

D. STROKE AND TRAUMA PROGRAM

1. Objectives

A major part of the research emphasis in the Stroke and Trauma Program is on cerebrovascular disease and stroke. In an aging population the large number of strokes and their sequelae are becoming more apparent.

The primary goals of the stroke program are:

(1) Continued and expanded efforts in basic research on cerebrovascular physiology and function.

(2) Additional epidemiologic studies of risk factors in order to improve means of stroke prevention.

(3) Prospective studies to document, in human beings, the various factors concerning the characteristics of natural growth, regression, and behavior of atherosclerotic plaques in cerebral blood vessels in order to develop better means of both primary and secondary prevention.

(4) Stimulation and support of research on the role of the hypothalamus and other CNS structures in controlling the level of blood pressure and in the cause of hypertension.

(5) Continued assessment of the need for and, where appropriate, continued support of clinical trials to evaluate new and existing techniques for stroke prevention, diagnosis, treatment and rehabilitation.

(6) Application of emerging technologies to study, analyze, diagnose, and treat cerebrovascular disease.

(7) Continued and expanded efforts in basic research concerning improved methods for measuring cerebral blood flow and cerebral metabolism.

2. Current and Planned Activities

(a) Major current activities have included:

Basic laboratory studies on cerebral hypoxia and platelet aggregation, clinical investigations of drug effectiveness, improvement of diagnostic devices and techniques, and improvement of surgical and medical procedures.

(b) Major planned activities include:

(1) Continued support of research on cerebral circulation and cerebral hypoxia.

(2) Initiation of a Stroke Clinical Research Program to determine the availability and efficacy of advanced care and treatment of stroke patients through controlled clinical research.

(3) Evaluation of noninvasive diagnostic techniques in stroke.

3. Major Program Highlights

Extensive baseline patient data was collected in regional comprehensive stroke centers for the purpose of determining the effectiveness of community stroke programs.

A nationwide program of research using Positron Emission Tomography was initiated to provide a better understanding of stroke and other disorders of the brain.

Considerable patient data was accumulated in an international cooperative study to evaluate a surgical bypass procedure for prevention impending stroke.

The pathogenesis of cerebrovascular disease was investigated in animal models.

OFFICE OF THE INSPECTOR GENERAL

Introduction

The mission of the Inspector General is to prevent and detect fraud and abuse in the Department of Health and Human Services (HHS) programs and to promote economy and efficiency in its operations. It is the Inspector General's responsibility to report to the Secretary and to the Congress any deficiencies or problems related to HHS programs and to recommend corrective actions.

The HHS Inspector General's Office is the first statutory position of its kind established in the Federal civil government. It was created by Public Law 94–505 enacted on October 15, 1976 and was the result of a Congressional initiative, inspired at least in part of disclosures of fraud, abuse or waste in Federal/State medical and welfare programs. The legislation places equal emphasis on the Inspector General's obligation to prevent or detect wrongdoing and his obligation to make recommendations for program improvements in HHS.

A basic philosophy of the Office of Inspector General (OIG) is to work in a coordinative and cooperative way with other organizations to accomplish its mission except when such a relationship would compromise the OIG independence. Close working relationships have been with the Health Care Financing Administration (HCFA), the Social Security Administration (SSA), and other major components of the Department in order to maximize resources devoted to common problems.

The Inspector General's Office is organized as follows:

The Assistant Inspector General for Auditing directs the HHS OIG Audit Agency which prepares or reviews more than 5,000 audits of HHS and its contractors and grantees annually.

The Assistant Inspector General for Investigations directs a staff that investigates activity of a potentially criminal nature against HHS programs.

The Division of State Fraud Control has a primary responsibility of working with the States to improve the detection and elimination of fraud against HHS programs and is the OIG manager of the State Medicaid Fraud Control Unit (SMFCU) program.

The Assistant Inspector General for Health Care and Systems Review directs a small staff of senior analysts with specialized experience across the range of HHS activities. This office also manages the Service Delivery Assessment (SDA) staff function for the Secretary.

The Executive Assistant Inspector General is responsible for management and legislative functions of the Office of Inspector General.

The Audit Agency and Office of Investigations have regional and branch offices. Each has 10 regional offices. The Audit Agency has 51 branch offices and OI has 18 branch offices.

The OIG has a number of current projects which have an impact on programs for the aging. The following are examples:

—*Project 90+.*—An Office of Inspector General match of 24,000 RSDI beneficiaries (over age 90) in metropolitan Chicago against Illinois death tapes yielded 25 unreported deaths. Current efforts are aimed at such matching for beneficiaries in the whole State.

—*Project spectre.*—In attempting to derive a profile for potential unreported deaths based on Medicare records, OIG found that HCFA computer files have death reports (from health providers) that SSA's computer system did not process to RSDI records. A match of HCFA's records of deceased Medicare patients against SA's RSDI master file found 8,518 active RSDI records and an estimated (based on sample projections) $60 million in accumulated overpayments.

—*SSI death match.*—An OIG 1979 match of SSI records against death records in California, Colorado, and South Carolina yielded 113 cases with total overpayments of $243,563 due to unreported death.

—*Project payment process.*—OIG will redevelop 109,000 RSDI benefit payment records from Treasury, including face-to-face interviews with a sample of beneficiaries in Los Angeles and Chicago. Unreported deaths, as well as errors in award and payment processes, should be uncovered.

—*Black lung review.*—This audit of Black Lung widows and spouses in Luzerne County, Pennsylvania screened sample beneficiaries against death records and now projects $5 million in annual overpayments due to unreported deaths.

—*Review of death terminations.*—OIG surveyed the death termination process and existing studies and interviewed key officials in SSA, General Accounting Office (GAO), Office of General Counsel, National Center for Health Statistics, Treasury Department and States to determine the scope of the problem of untimely death terminations and potential solutions.

—*Keys amendment.*—This OIG study is addressing the major problems found in boarding homes, the history of the Keys Amendment (Section 1616(E) of the Social Security Act), and current Departmental and State responses. This study includes data pertaining to the Best Practices of States on licensing and enforcement standards.

Numerous audits on programs affecting the elderly were conducted by the OIG Audit Agency during the past year. Eleven audit reports directly related to Title III of the Older Americans Act were issued in fiscal year 1981. A number of other reports were issued on programs affecting the elderly such as Supplemental Security Income, Retirement, Survivors and Disability Insurance, Medicare and Medicaid.

In the investigative area, the Inspector General's Office caseload is heavily dominated by health care cases, primarily Medicare and Medicaid. The Office of Investigations opened approximately 162 health care cases during fiscal year 1981. In addition, over 55 percent of the investigative workload involves SSA administered programs/operation.

Numerous Congressional hearings and General Accounting Office reports have indicated serious problems and vulnerability to fraud and abuse in programs for the elderly. The findings of these hearings are being consolidated in order to determine whether Congressional and GAO recommendations have been implemented.

Some examples are:

—*Home health agencies.*—Abuses of start-up and contractual arrangements (including consultant costs, fee for accounting and computer services, and management agreements); salaries and fringe benefits; and of patient solicitation have been identified. Recommendations have been made for changes in program administration by the various entities.

—*Durable medical equipment.*—Medicare pays more than may be necessary or appropriate; confusing and inadequate regulations and practices are some of the causes. Recommendations for improvements have been made in these areas.

—*Direct check deposit review.*—SSA will continue a plan for direct deposit (Electronic Fund Transfer) delivery for the SSI program. Recommendations to place this delivery method on a faster track in order to curtail lost and stolen checks were made in two sets of hearings held by the House Subcommittee on Intergovernmental Relations and Human Resources Subcommittee in fiscal year 1981.

OFFICE OF THE GENERAL COUNSEL

A. Health Care Financing Administration

1. *Erika, Inc.* v. *United States*, 634 F.2d 580 (Ct. Cl., 1980)

In this case, the Court of Claims held that it had jurisdiction to hear Medicare Part B cases (Supplementary Medical Insurance, including physicians' services) under the Tucker Act, 28 U.S.C. § 1491, notwithstanding the express preclusion of jurisdiction under the Medicare Act, 42 U.S.C. § 405(h). The district courts have refused jurisdiction over the Part B claims, either dismissing suits brought by Part B beneficiaries or transferring them to the Court of Claims.

On May 18, 1981, the United States Supreme Court granted the Department's petition for certiorari in this case. Meanwhile, the Court of Claims has stayed the remaining Part B cases.

2. *Estate of Picard* (S.D.N.Y., 1980)

The district court in this case ruled that for purposes of receiving Medicare benefits, the conclusion of a beneficiary's "spell of illness" is determined by the type of care the beneficiary receives rather than the type of institution in which the beneficiary resides.

Under § 1912(a)(1) of the Social Security Act, benefits inure for a limited number of days during each "spell of illness." Section 1861(a) of the Act prescribes that a "spell of illness" begins on the first day "on which an individual is furnished inpatient hospital or extended care services" and ends "with the close of the first period of 60 consecutive days thereafter on each of which he is neither an inpatient of a hospital nor an inpatient of a skilled nursing facility." The court held that a beneficiary was not an "inpatient" of a hospital or skilled nursing facility (SNF) if he received custodial but not hospital or SNF care during the 60-day period, and on that basis could end his "spell of illness."

3. *Gray Panthers* v. *Harris*, 652 F.2d 146 (D.C. Cir., 1981)

In this case, the Court of Appeals for the District of Columbia Circuit which had previously granted the Department's motion for rehearing, vacated its opinion filed in October 1980, and substituted an entirely new opinion.

The new decision reversed the lower court holding that the reconsideration procedures afforded to Medicare beneficiaries with claims of under $100 (which is a statutory prerequisite to the availability of an oral evidentiary hearing) satisfy the requirements of due process. Although the court did not find that Congress' elimination of formal hearing rights for disputes involving Medicare benefits of less than $100 renders the Medicare Act, itself, unconstitutional, the court held that the Secretary's interpretation of the Act presently provides insufficient protection of plaintiffs' due process rights. The court found that where elderly participants in a federally supported insurance program are permanently denied statutory benefits, due process mandates that they receive more protection than the present system allows. The court suggests that at a minimum the notice should specify with more precision and detail the basis for the denial, that claimant should be informed of or have access to the evidence on which the carrier relied in reaching its initial decision to deny the claim and, within a reasonable time thereafter, should have an opportunity to present evidence in support of his or her position. The case was remanded to the district court for a determination of the precise nature of the changes to be required in current procedures.

4. *McClure* v. *Harris*, 503 F. Supp. 409 (N.D. Cal. 1980)

The district court in this decision declared unconstitutional the use of carrier hearing officers to make final Medicare Part B (Supplemental Medical Insurance) hearing decisions. The court ordered that effective May 1, 1981, all claimants receiving adverse Part B decisions be offered the opportunity for a *de novo* evidentiary hearing before an administrative law judge.

The district court order has been stayed pending review by the United States Supreme Court. 101 S. Ct. 2298 (1981).

5. *Monmouth Medical Center* v. *Harris* (3rd Cir., 1981)

The court of appeals in this case affirmed the district court's decision favorable to the Department. Because of an acute shortage of nursing home beds, Medicare patients needing intermediate care facility (ICF) beds had been kept in hospitals while awaiting vacant ICF beds. The court ruled that the cost of hospital care for the hospital patients was to be disallowed starting from the time it was no longer necessary for the patients to remain in the hospital for medical reasons.

6. *Presbyterian Hospital of Dallas* v. *Harris*, 638 F.2d 1100 (5th Cir., 1981)

In this decision, the Fifth Circuit Court of Appeals held that neither the Medicare Act nor the First Amendment to the United States Constitution requires Medicare to pay hospital costs for patient telephones and televisions. The court ruled that while patients may have a constitutional right to communicate, they have no right to have the government fund those communications.

In addition, the court held that the hospital was entitled to be reimbursed for its costs incurred in rendering free care to patients unable to pay, which it was required to do as a condition of its Hill-Burton (42 U.S.C. § 291) loans. The court conceded that none of the Hill-Burton patients were Medicare patients, but noted that the lower interest rate the hospital paid under Hill-Burton was a benefit that affected all hospital patients, including Medicare patients.

7. *Schweiker* v. *Gray Panthers*, 101 S.Ct. 2633 (1981)

In this decision, the United States Supreme Court held that Medicaid's 1977 deeming regulations did not violate the statute. The challenged regulations permitted states exercising their statutory option under § 1902(f) of the Social Security Act not to cover under Medicaid all aged, blind and disabled persons receiving Supplemental Security Income (SSI), and to deem "excess" income of one spouse to an institutionalized spouse up to the amount and up to the period permitted in their 1972 Medicaid plans for purposes of determining Medicaid eligibility and amount of assistance of the institutionalized spouse.

The Supreme Court held that the court of appeals erred in invalidating the regulations on the ground that the Secretary had not considered all the relevant factors. According to the Court, Congress had already considered the relevant factors when it enacted the Medicaid program and permitted States to take into account financial responsibility of spouses for each other. Moreover, since the statute specifically delegated to the Secretary the responsibility of defining what constituted "available" income, the Secretary's decision in this regard was entitled to legislative effect, and not mere deference.

B. SOCIAL SECURITY ADMINISTRATION

1. *Blankenship* v. *Secretary of Health and Human Services* (W.D. Ky., 1981)

In this case, the district court, on remand from the United States Court of Appeals for the Sixth Circuit, in examining the issue of nationwide regulatory time frames in providing hearings and Appeals Council review in Social Security and Supplemental Security Income benefit claims. The court of appeals, in November 1978, ordered the Secretary to submit for district court review proposed regulations which set time frames for the hearing process. A Notice of Proposed Rulemaking, approved by the court in January, 1980, and published in the Federal Register, provided a limit of 90 days to hold a hearing and 30 days to issue a decision, subject to extensions for various circumstances. A final draft regulation, as submitted to the court in August, 1980, was changed in two major respects: the separate limits for hearing and decision were merged into one overall limit to maximize flexibility for the administrative law judges, and the time limit was expanded to 165 days because of vastly increased caseloads.

The final version of the regulation was "approved" by the district court in April, 1981; however, the court ordered that the Secretary design and submit a regulatory "sanction" proposal for dealing with those situations where the time frames were not met. Three "sanction" initiatives designed to address the court's concerns were submitted to the court in June; in conjunction with these proposals, the Department also requested leave to revise the regulatory time frames to provide generally a 180-day overall time frame for the hearing process.

While this submission was under court consideration, plaintiffs moved for an injunction requiring implementation of the 165-day time frame. On September 17, the court ruled that the "sanction" proposals were inadequate and granted the injunction, which the Social Security Administration's Office of Hearings and Appeals has implemented in Kentucky. The court also ordered further briefing on the 180-day proposal.

The Office of Hearings and Appeals has re-examined the entire question of time frame regulations and has concluded that no time limits regulations are reasonable in light of current workloads. Following the Secretary's decision that the Department seek relief from the court's orders requiring time frame regulations, motions and a memorandum were submitted which requested that the district court vacate its orders requiring regulations, on the grounds that current and projected increases in the hearings caseload (to over 415 000 hearing requests projected for fiscal year 1983) make a regulation establishing time frames unworkable. As of December 1, 1981, the issue remains unresolved by the court.

2. *Buffington, et al.* v. *Schweiker* (W.D. Wash., 1981)

The district court in this case ruled that a personal conference is automatically required under §204(b) of the Social Security Act before recovery of a beneficiary's overpaid benefits can begin.

In the 1979 decision of *Califano* v. *Yamasaki*, the United States Supreme Court had determined that when a beneficiary has been overpaid benefits, and has sought waiver of recovery, § 204(b) of the Social Security Act requires the Secretary to provide him or her an opportunity for a personal (oral) conference before recovery can begin. Upon remand, the district court held that once an individual requests waiver a personal conference must be automatically scheduled if waiver cannot be granted on the basis of the individual's written request.

3. *Benson* v. *Harris; Clark* v. *Harris; Doss* v. *Harris* (5th Cir., 1981)

Plaintiffs in these companion cases had appealed the respective district court decisions which, in upholding the Secretary's denial of benefits, had held that the Secretary's notice of claimant's right to counsel had been adequate.

The Fifth Circuit reversed the district court decisions, holding that when there is no waiver of right to counsel, the administrative law judge assumes a special duty to develop a full and fair record. Most significantly, in *Clark*, this meant that when the right to counsel at the administrative hearing has not been waived (because of inadequate notice) the claimant need not show that the presence of counsel would necessarily have resulted in any specific benefits in the handling of the case before the administrative law judge.

4. *Dwyer* v. *Califano* (3rd Cir., 1980)

In this case, the Third Circuit Court of Appeals reversed a decision of the district court which had required the Secretary to pay "deemed" widow's benefits to the plaintiff even though she did not qualify for benefits under the Social Security Act.

Section 216(h)(1)(B) of the Act permits, under specified conditions, a "deemed" spouse to qualify for benefits, if he or she in good faith married a wage earner but the marriage was invalid. However, the statute also provides that if the "legal" spouse is, or was, entitled to a Social Security benefit on the wage earner's account, the "deemed" spouse is disqualified from receiving benefits. The plaintiff participated in a marriage ceremony with the wage earner believing he had never been married. In fact, he was presently married. Plaintiff's benefits were terminated when the "legal" wife became entitled.

5. *Lamb* v. *Connecticut General Life Insurance Co.* (3rd Cir., 1980)

The court in this case determined that § 207 of the Social Security Act did not prohibit an insurance company which was paying disability payments under a private insurance policy from reducing the amounts payable as the insured's Social Security benefits increased due to annual cost-of-living increases.

The appellant's employer had contracted for an "integrated" group disability annuity policy, the provisions of which required any disability benefits payable under the policy to either a primary beneficiary or dependents to be reduced by "other income benefits" payable. She filed for and was awarded Social Security disability benefits and benefits under the private plan. The court of appeals rejected the appellant's argument that § 207 of the Act precluded the reduction under the private policy insofar as the statute prevents assignment or attachment of future Social Security benefits. The court reasoned that the reduction in the amounts payable under the private disability policy did not violate § 207, since it did not prevent the appellant or her dependents from receiving their full Social Security disability benefits.

6. *Martin* v. *Harris* (10th Cir., 1981)

The Tenth Circuit Court of Appeals in this decision sustained the Secretary's finding that plaintiff was not the "deemed" widow of the wage earner within the meaning of § 216(h)(1)(B) of the Social Security Act.

The statute provides that an applicant who is not the widow of a wage earner under applicable State law may nevertheless be entitled on his account as a "deemed" widow if she went through a marriage ceremony in good faith without knowledge of a legal impediment to the marriage. The statute further provides that the applicant is not entitled to benefits as a "deemed" widow if another individual "is or has been entitled" on the wage earner's account as a widow whose marriage was valid under applicable state law.

Plaintiff had participated in a marriage ceremony with the deceased wage earner resulting in an invalid marriage because, unknown to her, the wage earner had previously married another individual and had never divorced her. After the wage earner's death, the "legal" widow applied for and was found entitled to widow's insurance benefits on his account. These benefits were terminated when she remarried. Plaintiff then applied for widow's benefits as the wage earner's "deemed" widow. The application was denied because the "legal" widow had been entitled on the wage earner's account. Plaintiff challenged the denial arguing that there was no "legal" widow of the wage earner when plaintiff applied because the wage earner's former wife was married to another individual at that time. She also contended that § 216(h)(1)(B) of the Act violated the Fifth Amendment to the United States Constitution by giving priority to "legal" widows. Rejecting these arguments, the court affirmed the Secretary's reading of the statute as precluding the entitlement of a "deemed" widow where a "legal" widow has been entitled on the earnings record of the wage earner, even where the "legal" widow is not entitled at the time the "deemed" widow applies for benefits. The court further stated that the statute did not discriminate against "deemed" widows.

7. *Schweiker* v. *Hansen*, 101 S. Ct. 1468 (1981)

The United States Supreme Court in this case decided whether a claimant is entitled to an extra year of retroactivity on a written application for Social Security benefits beyond the one year period set out in the Social Security Act.

Due to erroneous information provided her by a Social Security Administration (SSA) employee, the claimant did not file for benefits when she was first eligible. The Second Circuit Court of Appeals held that SSA was estopped from denying her the additional benefits because of the misinformation provided by the SSA employee. The Supreme Court, while not deciding what type of conduct by a government employee will estop the government, reversed the court of appeals decision and held that under the circumstances in *Hansen* estoppel would not lie. The Court restated "the duty of all courts to observe the conditions defined by Congress for charging the public treasury," and held that the employee's conduct in this case (less than "affirmative misconduct") did not justify "the abnegation of that duty." In so holding, the Court upheld the validity of the Secretary's regulation requiring that application for Social Security benefits be in writing, and noted that a court is no more authorized to overlook such a valid regulation "than it is to overlook any other valid requirement for the receipt of benefits."

8. *Tornow* v. *Schweiker* (C.D. Ill., 1981)

In this decision, the district court upheld the constitutionality of § 202(k) of the Social Security Act, which provides for the reduction of widow's benefits on her deceased husband's account by the amount of the widow's retirement benefit on her account.

Plaintiff had attacked the offset provision as being a denial of due process and equal protection on three grounds: (1) it allegedly denies a deceased covered contributor with a surviving contributing spouse the same benefits as one with a surviving non-contributing spouse; (2) it allegedly denies a covered contributing surviving spouse entitled to her own benefits the same derivative benefits as a non-covered, non-contributing spouse; and (3) since women survive their husbands in more cases, it allegedly results in gender-based discrimination.

The district court found that it is constitutionally permissible to set a maximum survivor's benefit by providing a reduction as a reasonable means to increase funding for the whole program. Furthermore, the court found that, as to the first point, plaintiff lacked standing to represent her deceased husband. Finally, the court found that since § 202(k) treats men and women equally, there was no gender-based classification which violated plaintiff's constitutional rights.

ITEM 7. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

DECEMBER 18, 1981.

DEAR MR. CHAIRMAN: Per your request of September 10, 1981, I have enclosed a copy of the U.S. Department of Housing and Urban Development's 1981 annual report to the U.S. Senate Special Committee on Aging.

Very sincerely yours,

SAMUEL R. PIERCE, Jr., *Secretary*.

Enclosure.

1981 ANNUAL REPORT TO THE SENATE SPECIAL COMMITTEE ON AGING

INTRODUCTION

The Department of Housing and Urban Development's efforts to serve the elderly are characterized by concern to maintain and focus housing and services while achieving necessary budget savings. Under Secretary Pierce, HUD has acted to assert administrative responsiveness and direction, to insure housing production, to provide opportunities for necessary auxiliary services, to protect the elderly it serves, and to pursue extensive research aimed at improving the quality of life of aging Americans.

This report to the Special Committee on Aging of the U.S. Senate is organized to show the pattern of HUD service, and the sections of the report are ordered to give a comprehensive view of HUD policy and programs. Coordination of services for the aging has been given administrative priority by being located in the Office of the Secretary, under the direct supervision of the Deputy Under Secretary for Intergovernmental Relations. Programs of direct loans and loan guarantees to provide adequate production of housing for the elderly are being maintained, and various offices of HUD are exploring methods of protection and service to the elderly we house. HUD encourages use of community development funds to complement HUD services through State and local discretion; this report describes some of the ways this is already being accomplished. Finally, there is a presentation of current and projected research, and interagency agreements aimed at discovering useful ways of improving housing and services for the elderly.

The Department of Housing and Urban Development enters this period of fiscal restraint and recognition of the limits of Government spending, confident that its program for the elderly and willingness to respond to their needs will provide the flexibility and level of support necessary to meet the requirements of the 1980's for decency in housing for older Americans.

I. OFFICE OF THE DEPUTY UNDER SECRETARY FOR INTERGOVERNMENTAL REGULATIONS

In March 1981, Secretary Pierce of the U.S. Department of Housing and Urban Development (HUD) established the Office of the Deputy Under Secretary for Intergovernmental Relations as a new organization within the Office of the Secretary. This office serves as the focal point for secretarial dealings with the White House, with the other Federal agencies, with State and local officials, and with public interest groups on intergovernmental policy matters.

In May 1981, Secretary Pierce transferred the responsibility for policy recommendation and program coordination of functions relating to the elderly to the Office of the Deputy Under Secretary for Intergovernmental Relations. The position of Special Adviser for the Elderly was transferred to this office.

The responsibilities of the Office of the Deputy Under Secretary for Intergovernmental Relations include maintaining contact with public interest groups representing the elderly and responding to their concerns about Department programs, working with the White House and HUD program offices to insure specific attention to the elderly population's concerns, and handling casework problems involving elderly populations. This office also works with the White House Conference on Aging, American Association of Retired Persons, National Association of Area Agencies on Aging, Urban Elderly Coalition, National Council of Health Centers, the Senate Special Committee on Aging, the Administration on Aging (HHS), the Information and Referral Task Force (Interagency), the White House Conference on Independent Living for Elderly Consumers, and the President's Committee on Physical Fitness.

II. HOUSING

A. Section 202—Direct Loans for Housing for the Elderly or Handicapped

The section 202 program was first enacted as a part of the Housing Act of 1959 to provide direct Federal long-term loans for the construction of housing for the elderly or handicaped. The program was intended to serve elderly persons whose income was above public housing levels but still insufficient to obtain adequate housing on the private market. The section 202 program was amended by the Housing and Community Development Act of 1974 to change the method of determining the interest rate (which had been set at 3 percent statutory maximum in 1965) and to permit the use of section 8 housing assistance payments for projects constructed or substantially rehabilitated under the program. In fiscal year 1981, the interest rate was 9¼ percent. In fiscal year 1982, the interest rate will be 11¾ percent.

Since reactivation of the program in 1974, nearly $5 billion has been reserved, representing 1,992 projects and 130,728 units. At the end of fiscal year 1981, 295 projects with 14,728 units had received fund reservations for $698.3 million. Approximately $850 million (estimated to finance the development of 17,000 units) will be available for fund reservation in fiscal year 1982.

B. Section 231—Mortgage Insurance for Elderly Housing

Section 231 of the National Housing Act, as amended, authorizes HUD to insure lenders against losses on mortgages used for construction or rehabilitation of rental accommodations for older persons (aged 62 years or older—whether married or single).

Section 231 is HUD's principal program designed solely for unsubsidized rental housing for the elderly. Nonprofit as well as profit-motivated sponsors are eligible under the program, and section 8 housing assistance payments can be made available on a competitive basis. Section 231 permits congregate housing projects to be built.

During fiscal year 1981, the Department insured five projects consisting of 967 units, bringing the total number of projects currently insured under the section 231 program to 495 projects consisting of 66,285 units.

C. Section 221(d) (3) and (4) of the National Housing Act—Mortgage Insurance Programs for Multifamily Housing

While these programs are not specifically for the elderly, they are available to sponsors as alternatives to the section 231 program.

Section 221(d)(3) and (4) authorized the Department to provide insurance to finance the construction or rehabilitation of rental or cooperative structures. Special projects for the elderly are provided under these programs.

In fiscal year 1981, 826 projects containing 72.263 units were insured under these programs. Since their inception, these programs have insured 8,771 projects containing 937,414 units. More than 10 percent, or 97,663 units, are for the elderly.

D. Section 223(f)—Mortgage Insurance for the Purpose of Refinancing Existing Multifamily Housing Projects

This program offers mortgage insurance for existing facilities, including housing for the elderly, where repair needs do not warrant substantial rehabilitation. The program can be used either in connection with the purchase of a project, or for refinancing only. To the extent that real estate liquidity is enhanced, the availability of section 223(f) encourages investment in residential real estate of all kinds. Prior to its being added to the National Housing Act in August 1974, project mortgage insurance could be provided only for substantial rehabilitation or new construction.

E. Section 232—Mortgage Insurance for Nursing Homes/Intermediate Care Facilities

The primary objective of the section 232 program is to assist and promote the construction and rehabilitation of long-term care facilities. The vast majority of the residents of nursing homes are elderly.

Since the program's enactment in 1959, the Department has insured 1,326 facilities, providing 152,255 beds, totaling $1.7 billion. In fiscal year 1981, the Department insured mortgages on 31 new projects with 3,809 beds, with a value of $110 million.

F. Section 8 Rental Assistance

Legislation requires that section 8 projects serve lower income and very low-income families. Further, some projects are developed with a mix of assisted families. No family assisted under section 8 may pay more than 25 percent of its income for rent. The rental payment may be as low as 15 percent, however, depending on family income, size, and medical or other unusual expenses.[1]

Current statistics. As of August 31, 1981, of the total of 1,278,754 living units which have been added to the housing stock for "section 8" certification, including existing units, 539,934 were for the elderly—this is more than 40 percent. Average housing assistance payments for fiscal year 1981 were as follows: New construction $3,653; substantial rehabilitation $4,071; and existing housing $1,928.

It is expected that field offices will have only very limited section 8 contract authority in fiscal year 1982. New projects, and many projects currently in processing, will be subject to cost-containment measures already promulgated or under review.

G. Public Housing

Public housing was created by the United States Housing Act of 1937 and has always included the elderly as eligible residents. In 1956, public housing especially designed for the elderly, incorporating safety and security features, was authorized by the Congress. Handicapped persons of all ages with low incomes are statutorily included. Public housing agencies (PHA) develop and operate the housing, financed through direct HUD loans and the sale of bonds and other obligations. The Federal Government assists with annual contributions to repay the PHA borrowings and, with operating subsidies, assures that low rents and adequate services are available.

In 1970, legislation was enacted encouraging PHA's to develop congregate rental housing for the elderly and handicapped. "Congregate housing" differs from the usual multiunit housing in that the living units may or may not have individual kitchens but must have a central kitchen and dining facility to make possible the serving of communal meals. Supportive services may be provided by the PHA but most are provided by local social services agencies funded by the Older Americans Act and titles XIX and XX of the Social Security Act.

In overall production of housing for the elderly and handicapped, fiscal year 1981 showed completion of 7,953 living units. Of these a total of 6,437 were new construction; 1,508 were substantial rehabilitation; and 8 were acquired units of existing housing. Public housing construction starts for the "elderly" totaled 12,062, of which 10,932 were new units and 1,130 were substantial rehabilitation. This amounts to 34 percent of the total construction starts. Section 8 units are not included in these figures. Production of congregate housing has been relatively limited.

H. Indian Housing

The Department provides housing assistance for elderly Indians and Alaska Natives pursuant to the U.S. Housing Act of 1937, as amended. The Indian housing program is similar to the public housing program. Indian housing authorities operate rental and homeownership programs on reservations.

As of October 1, 1981, there were almost 170 Indian housing authorities operating approximately 41,400 units of Indian housing of which approximately 2,500 units specifically house elderly families. Approximately 15,290 units are in the development pipeline and will be available for occupancy within the next 3 years; of these units in development, about 10 percent are for the elderly.

The Indian Housing Office is implementing a special group homes project, the Menninger Project, jointly financed by HUD and Health and Human Services. Group homes are being constructed which will serve the handicapped and disabled, including elderly individuals. All of the homes will be operated by the IHA's as low-income housing projects; rents will be based upon the tenants' available income. This program will enable the tribal agency to spend its funds on support services rather than for housing. Some of the tribal agencies have service programs in operation and have already received commitments for funds to operate the group homes.

I. Congregate Housing Services Program

The congregate housing services program is a demonstration designed to test the cost-effectiveness of this type program for the elderly and handicapped. Under this program HUD extends multiyear grants (3 to 5 years) to eligible public housing authorities and nonprofit section 202 borrowers for meals and other supportive services to frail elderly and nonelderly handicapped residents to help them remain independent.

---

[1] NOTE.—These statements, while correct for fiscal year 1981, are being changed to reflect the Housing and Community Development Amendments of 1981 incorporated in the Omnibus Budget Reconciliation Act of 1981 (Public Law 97–35).

As of 1981, all fiscal year 1979 moneys had been committed to grantees, except for some $400,000 that was legislatively required to be held back to cover the cost of inflation and other adjustments. Thirty-one of these grants are in operation serving approximately 1,600 residents. Grants for six new construction projects will not be negotiated until initial occupancy in 1982.

$10 million was available in fiscal year 1980 for grantees. Of this amount, $6 million was committed to the grantees. These grants were for 5 years. They serve approximately 800 residents a year in 18 projects. Fourteen are now operational. The remainder are in the process of final contract negotiations.

The $3 million of fiscal year 1980 funds reserved for new construction projects will be allocated by competitive selection in fiscal year 1982.

J. Interstate Land Sales

Congress passed the Interstate Land Sales Full Disclosure Act in 1968 to give the public a measure of protection against fraudulent and deceptive land sales operations. The act is administered through HUD's Office of Interstate Land Sales Registration. Although the act is intended to provide protection for all consumers, it is evident that a greater number of potential victims of fraudulent land sales could be the elderly.

The property report is the key to the protection available to consumers under the act, since developers are required by law to give the prospective purchaser a property report prior to or at the time of signing a contract. In the last few years allegations of overregulation by the land development industry and increased congressional interest resulted in extensive amendments to the act in December 1979. These amendments, which became effective in June 1980, created new exemptions from the act's registration requirements in certain cases where lack of disclosure to purchasers is deemed not to have an adverse effect. Also, as provided for in the recent statutory changes the Department has conducted negotiations with several States concerning the certification of their land sales efforts as equivalent to protections provided by Federal law. Thus far, the States of California and Minnesota have been certified, which will effectively reduce the Federal presence in those States. The act's antifraud and antimisrepresentation provisions still apply.

III. COMMUNITY PLANNING AND DEVELOPMENT

A. Community Development and Block Grants (CDBG)

The community development block grant (CDBG) program is a major funding source for cities to conduct a wide range of community development programs. It makes available approximately $3.5 billion annually to communities, of which approximately $2.5 billion goes to 650 cities and urban countries by entitlement—with the amounts determined by formula. $1 billion goes to approximately 2,000 small cities under 50,000 population which compete through States and HUD area offices. Block grants must be expended to help low- and moderate-income households, to eliminate slums and blight, or to meet urgent community development needs. The primary objective of the legislation is the development of viable urban communities by providing decent housing, a suitable living environment, with expanding economic opportunities—principally for persons of low- and moderate income.

Those cities entitled to block grant funds have directed about 57 percent of their funds (close to $1 billion) in each of the past 3 years to areas in which at least 10 percent of the population was 65 or more years of age. In 1978 and 1979 about $260 million of those funds were used for rehabilitation or code enforcement projects designed to improve the quality of housing. It is estimated that in 1980, funding for housing improvement projects for those areas with a high proportion of elderly residents was over $300 million.

Areas with a very high concentration of elderly persons (i.e., those in which at least 20 percent of the population was 65 or more years of age) received, on average, $31.5 million annually from 1978 to 1980 for housing improvement programs.

Some of the more popular CDBG home improvement projects intended for elderly persons have involved lowering the interest rates of conventional home improvement loans, deferring repayments of loans from the local government for a specified period of time, approving home improvement grants for elderly homeowners, and improving and weatherizing the homes of elderly citizens.

Block grant entitlement communities are also required to develop housing assistance plans (HAP's). Following the guidelines established by HUD, entitlement block grant applicants plan their housing assistance in proportion to the need of each type of household in their community (e.g., elderly/handicapped, small family, and large family). While cities have the latitude to adjust their housing goals either to correct past imbalances in goals or due to local circumstances, in general, communities receiving CDBG entitlement funds have indicated that about 15 percent of the housing assistance needs of elderly/handicapped households in their communities will be addressed over the next 3 years.

B. Urban Development Action Grants

The urban development action grant (UDAG) program provides grants to cities and urban counties which meet minimum standards of physical and economic distress. The purpose of the program is to improve the economic base of those cities and provide permanent jobs, especially for low- and moderate-income persons. The program seeks to attract private investment to distressed localities; no grants are approved unless there are firm commitments of private funds to carry out project development. Preliminary approvals of action grants are based upon nationwide competition on a series of factors including the relative distress of the city, how much private money is attracted by the UDAG grant, the number of jobs created, the seriousness of the economic problems of the locality, and other factors. In 1979, a "pockets of poverty" provision was added to the program, permitting localities which are not distressed to apply for grants to assist areas of the city which have many low-income households.

Since 1978, 63 projects in 26 States and Puerto Rico have been awarded funds which help to meet the needs of the elderly. Listed below are projects approved during 1981 which directly benefit elderly households.

Wilmington, Ohio	Develop affordable elderly rental housing.
Corvallis, Oreg	Rehabilitate a historic building for affordable elderly rental housing.
Pittsburgh, Pa	Construct a minority owned and oriented nursing home and outreach center.
Vega Baja, P.R	Construct a hospital in an area lacking adequate medicare certified health facilities.
Durand, Wis	Extend utilities and provide site improvements for a 30-bed hospital and a 60-bed nursing home.
Toledo, Ohio	Construct living care center and doctor's office adjacent to an existing hospital.
Willow Springs, Mo	Provide water services to a new 60-bed nursing home.

C. Section 312

The section 312 rehabilitation loan program, as established by the Housing Act of 1964, provides direct, low-interest loans to eligible property owners to enable them to finance the rehabilitation of their properties. The properties, in general, must be located in specific Hud-assisted areas, the most common of which are community development block grant activity areas. The Congress has directed that priority be given to low- and moderate-income occupants.

Loans may be made on most kinds of properties (single family residential, multifamily residential, nonresidential, homesteading), but most section 312 funding has gone for single family loans, including homesteading. In addition, 1980 legislative amendments clarified the authority of localities to make loans to properties containing congregate housing dwelling units and to single room occupancy properties. Rehabilitation loans have traditionally been made at a 3-percent interest rate, but legislative authority exists to make loans to borrowers whose incomes exceed 80 percent of the median income for the area at increased interest rates, up to the current average market yield of Treasury securities of comparable terms, adjusted to the nearest one-eighth of 1 percent. The term of the loan is the shortest reasonable term consistent with the borrower's ability to pay; but, in no instance, is the term more than 20 years.

In fiscal year 1980, 16.6 percent of section 312 rehabilitation loans were made to persons who were 62 years of age or older. These loans accounted for 11.8 percent of the total section 312 funds available for that fiscal year.

The fact that the percentage of section 312 "funding" is lower than the percentage of "loans" indicates that elderly borrowers tend to use section 312 loans to do basic repairs to their homes, rather than to undertake major rehabilitation projects. In addition, 8 percent of the tenants in multifamily structures assisted by section 312 funding are rented to elderly persons.

IV. ASSISTANT TO THE SECRETARY FOR LABOR RELATIONS

While this office does not have programmatic responsibilities per se for "elderly" housing, it has a substantial impact because labor costs are 25 percent of housing construction and 50 percent of public housing maintenance. These costs obviously affect housing for the elderly. Perhaps more than any other factor the Davis-Bacon prevailing wage statute has adversely impacted housing for the elderly. HUD has worked with the Department of Labor on proposed regulatory reform and is optimistic that much of the present estimated costs of the statute, $2.8 billion, can be saved, and thus make more money available for housing for the elderly.

The Labor Relations Office coordinates the anticrime program. This office works with local housing authorities to continue the programs from other funding sources. The resident caretaker program has been one of the most effective programs in reducing crime in improving maintenance at public housing projects.

V. POLICY DEVELOPMENT AND RESEARCH

Title V of the Housing and Urban Development Act of 1970 authorizes and directs the Secretary to undertake programs of research, studies, testing, and demonstrations relating to the mission and programs of the Department. Section 815 of the Housing and Community Development Act of 1974 strengthened the role of HUD research in the areas of elderly and handicapped by specifically encouraging demonstrations related to the housing problems of members of special user groups.

The focus on research related to the problems of the elderly and handicapped is in HUD's program of special user research, although other program areas also support research which has an impact on the elderly and handicapped.

The mission of the special user group research program is to design, conduct, and support research and demonstration projects whose results will improve housing conditions and related housing and community services for the elderly, the handicapped, and other members of identifiable special user groups.

A. Current Special User Research

The Office of Policy Development and Research has recently completed or is currently sponsoring several projects related to the housing problems of the elderly; work will continue in 1982. The following list demonstrates the scope of these recently completed and ongoing projects:

—One initiative which began in 1978 and continued through 1981 was an evaluation of Baltimore's experimental home maintenance program. The program's objective is to help eligible households living within the target area with minor maintenance and repair problems.

—Persons living in the area who are either 55 years of age or older, physically handicapped, or single parent householders, are eligible for the program. Early evaluation results of this two-stage study form the basis for a multicity demonstration of the home maintenance and repair program concept. The demonstration continued its operation through 1981 and the evaluation work was ended.

—1981 saw the first year of operation of the seven-city elderly home maintenance demonstration. Enrollment targets of 125 clients per city were met, and inspection and repair services delivered on target. Administrative support was provided to the sites and the baseline data needed for evaluation was collected. Preliminary indications are that the demonstration is providing a much needed service. The demonstration will continue through 1982.

—The Gerontological Society completed development of a research agenda for HUD on issues related to the housing needs of the elderly. The agenda will guide our program over the next several years.

—A companion to the book, "Low Rise Housing for the Older People" was completed. Its focus is on the special design problems of providing mid-rise and high-rise elevator buildings to meet the social needs of the elderly.

—During fiscal year 1981, P.D. & R.'s evaluation of the congregate housing services program (CHSP) produced a preliminary report on the planning and implementation processes for the fiscal year 1979 grantees and descriptive information on service availability at randomly selected nongrantee projects. Baseline data collection on individual participants and residents at randomly selected "control" projects began. This data will be used to provide premeasures of CHSP program impacts on rates of institutionalization, hospitalization, mortality, physical functioning/health status measures, life satisfaction measures, whether the services are substituting for privately (i.e., family, friends) provided supportive services, and whether the services were being targeted to the most needy. In 1982, the data collection effort will be repeated to obtain post-measures of impact on the above variables. Preliminary analyses of targeting and resident profiles will commence after baseline data collection is completed; however, the complete impact analysis and evaluation results will not be available until mid-1984.

The second major focus of the special user research program is on the handicapped; much of that research has major implications for the elderly.

—An evaluation of the demonstration for housing the chronically mentally ill, including the elderly, was conducted. Phase I, which examined the problems of implementing such a program, was completed. Phase II, which will examine the costs and benefits of such housing, will be sponsored by the Health Care Financing Administration of Department of HHS.

—A cost study of the implications of section 504 for the retrofitting of public housing, combined with a similar analysis of the cost of retrofitting for energy conservation and modernization, was completed.

VI. OFFICE OF FAIR HOUSING AND EQUAL OPPORTUNITY

A. The Age Discrimination Act

Congress passed the Age Discrimination Act in 1975 to prohibit discrimination on the basis of age in programs or activities receiving Federal financial assistance. The Department of Health and Human Services (HHS) is the agency responsible for coordinating the governmentwide implementation of the Age Discrimination Act.

Under HHS' governmentwide implementation plan, each Federal agency was asked to publish a proposed regulation defining Age Discrimination Act policies and procedures which apply to recipients of Federal financial assistance. HUD prepublished a proposed regulation in the Federal Register on November 4, 1980. No further action has been taken on this proposed regulation pending an agreement between HHS and OMB on the self-evaluation process.

B. Section 8 Minority Business Enterprise Demonstration Program

The section 8 minority business enterprise (MBE) demonstration program is designed to help minority-owned businesses gain a greater share of the housing industry. In fiscal year 1981, this program allocated almost $10.2 million in contract authority to fund 1,677 units of section 8 housing in 27 projects located in 19 States, the District of Columbia, and Puerto Rico. More than one-third of the units funded will be exclusively for the elderly.

VII. GOVERNMENTAL NATIONAL MORTGAGE ASSOCIATION

The Government National Mortgage Association (GNMA) operates two major programs. Under its mortgage-backed securities program, GNMA guarantees the timely payment of principal and interest on securities issued by private financial institutions and backed by Government-underwritten mortgages. This program is designed to provide a mechanism through which residential mortgages and other loans can obtain funding through access to the overall resources of the Nation's capital markets.

Among the various types of mortgages which are eligible to collateralize a GNMA security, are FHA-insured section 232 nursing homes. During fiscal year 1981, a total of 32 nursing home projects with an aggregate mortgage amount of $92,691,200 were financed through the GNMA-guaranteed mortgage-backed securities program. In addition to those elderly persons that are housed through the financing of nursing homes, senior citizens also benefit from GNMA's mortgage-backed securities program since it provides the majority of funds used to finance the purchase and sale of new and existing FHA-insured and VA-guaranteed home mortgages.

Under GNMA's other major program, the mortgage purchase or so-called tandem program, GNMA provides below-market interest rate permanent financing for certain types of eligible FHA-insured multifamily projects. During fiscal year 1981, a total of $27.4 million was committed to refinance and rehabilitate 28 projects under a demonstration program operated in conjunction with HUD's section 223(f) insurance program. These buildings house elderly citizens in New York, Columbus, and Indianapolis, as well as in other communities. In addition, GNMA also provided $1.5 billion in commitments to purchase mortgages on section 8 projects throughout the Nation. A portion of this housing will also be used to meet the housing needs of the elderly.

VIII. INTERAGENCY AGREEMENTS

A. Alcoholism w/HHS

A HUD–HHS agreement was formulated and signed to organize and present a series of alcoholism outreach programs at selected PHA's across the country. The alcoholism programs were designed to deal with the problems of alcoholism as it affects family life, especially the lives of youth and the elderly. Attention was also given to the interaction of alcoholism and housing management.

B. White House Conference on Aging

HUD cooperated with White House staff and D/HHS on preparation of materials and logistic details for the White House Conference on Aging. For the Housing Committee of the WHCoA, HUD prepared summaries of issues in housing. Staff served as facilitators and resource persons during the Conference.

C. Title III–C Nutrition Program w/HHS (AoA)

Agreements in effect between HUD and the Administration on Aging on nutritional and social services for the elderly in HUD-assisted housing continue to produce programs and services. For example, as reported last year, over 1,500 local housing authorities and section 202 sponsors provide onsite facilities for the AoA title III–C nutrition program under an agreement between HUD and AoA. We estimate these sites serve at least 25,000 elderly.

ITEM 8. DEPARTMENT OF THE INTERIOR

DECEMBER 1, 1981.

DEAR MR. CHAIRMAN: Secretary Watt has asked me to respond to your September 10, 1981, request concerning the 1981 annual report of the Senate Special Committee on Aging entitled, "Developments in Aging." We appreciate the opportunity to submit information from this Department for the report.

Our bureaus and offices have been surveyed on the developments in aging in their programs and services, and we are pleased to submit their reports in line with guidance received by contact with your communications director. The attached reports demonstrate Department policy on equal opportunity for the aging in our personnel practices and in our programs and services to constituents. The reports demonstrate efforts to insure nondiscrimination against the aging in employment opportunities and progress in making our programs, services, and facilities more accessible to senior citizens. These concepts are supported with more detail in the reports from our personnel and equal opportunity offices, the National Park Service, and other bureaus. We recognize, and strive to be responsive to the complexities of the issues of gerontology.

Again, we thank you for the chance to contribute to your annual report, and we commend the activities of the Special Committee in addressing the problems and expanding the opportunities of older people.

Sincerely,

J. Robinson West,
Assistant Secretary for Policy,
Budget and Administration.

Enclosures.

Office of Policy, Budget and Administration

In the Department we announce all positions, except firefighters and law enforcement positions, as open to all applicants regardless of age. In the Department we have 311 employees on the rolls who were 70 or over as of October 1, 1981. There are 10 employees in their eighties still on the rolls. The 311 persons are employed at all grade levels from GS-1 through GS-15. The type of appointments include career, career conditional, wage grade, wage board, foreign, and temporary.

Public Law 95-437, the Federal Employees Part-time Career Employment Act of 1978, provides career part-time employment opportunities in positions through GS-15 (or equivalent) subject to agency resources and mission requirements. This program is attractive to older persons with the skills, experience, and qualifications to reenter the job market on a part-time basis.

We are implementing revised/new OPM initiatives. As a result of the decision in *Moysey* v. *Andrus*, the regulation on medical reexamination of annuitants who are age 60 and over has been revised. Under the revised regulations, any annuitant who is age 60 or over may now request medical reexamination to determine if he or she has recovered from the disabling condition on which his/her annuity is based.

In the recent disability retirement study conducted by OPM, it was determined that OPM policy discouraged the reemployment of disability annuitants by limiting such employment to temporary appointments of less than 1 year. This policy resulted in many annuitants being retained on disability retirement longer than was necessary. The revised disability retirement regulations now permit a disability annuitant to be reemployed in any position for which he/she is qualified, with the kind of appointment otherwise appropriate under the circumstances. The reemployed annuitant will have his/her pay offset by the amount of annuity allocable to the period of reemployment. A disability annuitant so employed may request to be found recovered at any time, and when the nature of the appointment is such that it would otherwise be subject to retirement deductions, OPM will terminate the annuity as of the date of its administrative finding of recovery and the agency shall commence retirement deductions as of the same date. These revised procedures will encourage reemployment among the employable disability annuitants while protecting the right to future benefits of those not fully recovered.

Office of the Secretary, Equal Opportunity Officer

During 1981:

(1) EEO policy statement issued by the Principal Deputy Assistant Secretary for Policy, Budget and Administration, updating and strengthening previous statements, sent to all OS/ODO office heads and to EEO coordinators for their distribution to employees in their organizations. The statement covers age as one of the protected classes and requires fair and equitable treatment in *all* personnel management matters.

(2) OS/Equal Opportunity Office continues to process complaints of discrimination based on age and with the cooperation of various offices, is successful in resolving or preventing many complaints at the lowest possible level.

(3) Selections of EEO coordinators and counselors, as well as other OS/ODO appointments, reflects responsiveness on the basis of age.

(4) Monthly meetings with EEO coordinators and EEO counselors have included special forums on the need for sensitivity, responsiveness, and effective communications pursuant to age.

(5) The OS/EEO Advisory Council includes age discrimination as a prohibitive factor in its planning and deliberations.

(6) Personnel/EEO update, a series of special seminars targeted to managers, supervisors, EEO coordinators, EEO counselors, as well as all OS/ODO employees, during the week of November 16, 1981, will include discussions on age.

(7) Community relations activities include meetings, forums, lectures, and organizational activities to help sensitize attitudes and treatment on the basis of age.

EEO POLICY STATEMENT

Equality of opportunity is a high priority responsibility in the Department of the Interior. It helps the Department to accomplish its mission through more efficient and effective management and in equitable policies and fairer treatment for all employees.

The Equal Employment Act of 1972 (Public Law 92–261) outlaws discrimination in Federal agencies in any personnel action on the basis of race, color, religion, sex, and national origin, and requires Federal agencies to submit regional and national affirmative action plans.

The Civil Service Reform Act of 1978 (Public Law 95–454) requires:

—Fair and equitable treatment in all personnel management matters, without regard to politics, race, color, religion, national origin, sex, martial status, age, or handicapping condition, and with proper regard for individual privacy and constitutional rights.

—High standards of integrity, conduct, and concern for the public interest.

—Development of Federal equal opportunity recruitment programs (FEORP) to recruit minorities and women as a remedy to underrepresentation.

—Success in meeting affirmative action goals as one of the evaluative criteria for retention in the Senior Executive Service.

Such requirements shall be integrated into daily management decisions and institutionalized into long-range planning toward successful accomplishment of the Department's mission.

In pursuance of such objectives, and in our efforts to reduce the possibility of waste and mismanagement, wherever there are problem areas in employment profiles, managers shall take necessary action such as transfer, detail, training, job restructuring, upward mobility, or other legal and regulatory actions to correct them.

The attached bottom line is suggested for use by managers and supervisors as a results-oriented checklist.

THE BOTTOM LINE: A RESULTS-ORIENTED EEO CHECKLIST FOR MANAGERS (FOR USE IN INTEGRATING EEO INTO DAILY MANAGEMENT DECISIONS AND IN INSTITUTIONALIZING IT INTO LONG-RANGE PLANNING)

1. Organization and resources.
2. Supervisory and management awareness and commitment.
3. Affirmative action plans/FEORP: Fiscal year goals.
4. Underrepresentation.
5. Underutilization/concentration.
6. Plans for filling actual and projected vacancies.
7. Recruitment/advertising/readvertising.
8. Integration of AA, removal of barriers in budget and other managerial processes.
9. Vacancy announcement and request for personnel action (form 52).
10. Applicant referral file.
11. Data collection, e.g., minority group designations.
12. Selection procedures.
13. Task analysis/job restructuring/crossover/skills upgrade/bridge methods.
14. Reorganization: Impact on EEO.
15. Co-op program, e.g., junior fellowship, baccalaureate, graduate.
16. Summer employment.
17. Special emphasis programs, e.g., Hispanic employment program, Federal women's program, and others.
18. Special appointing authorities, e.g., veterans employment program, selective placement program.
19. Intergovernmental Personnel Act (IPA) assignments.

20. Hires.
21. Assignments/transfers/reassignments/details.
22. Promotions.
23. Separations/reductions-in-force.
24. Senior Executive Service.
25. Feeder group I.
26. Executive and management development program (feeder group II).
27. Selection for appointments to committees, councils, commissions, boards, task forces, etc.
28. Full utilization of skills and training, including upward mobility.
29. Departmental projects, conferences, observances, e.g., Federal women's week.
30. Peformance appraisal/standards.
31. Communications, e.g., staff meetings.
32. Community outreach/public relations.
33. Awards/bonuses/commendations.
34. Discrimination complaints/counseling: Timely cooperation in resolution at lowest possible level.
35. Contracts with minority and women's businesses (monitored by Office of Small and Disadvantaged Business Utilization).
36. Title VI programs (monitored by Office for Equal Opportunity).
37. Accomplishments: Reports.
38. Assessments: EEO statistics of minority groups, sex, handicapped occupational series, grades (on hiring, promotion, training, and other personnel actions) as compared with totals and with previous years.

AGE DISCRIMINATION ACT OF 1975

Below is a chronology of the actions taken by this office regarding publication of the Department's final rule for enforcement of the Age Discrimination Act of 1975:

January 3, 1980.—Interior's proposed rule published in the Federal Register.

March 3, 1980.—Interior's proposed final rule sent to the Department of Health, Education, and Welfare (HEW) (now Health and Human Services (HHS)) for approval.

March 3, 1980.—Proposed final rule to Solicitor's Office and to the Office of Directives Management for preliminary review and approval concurrent with HEW review and approval.

March 13, 1980.—Memorandum received from Directives Management recommending minor style changes which were made.

April 1, 1980.—Memorandum from the Solicitor's Office stating no objection to publication of the final rule.

June 4, 1980.—Letter from the Assistant General Counsel, Department of Health and Human Services, stating that they have our proposed final rule but, because of a dispute with the Office of Management and Budget (OMB) regarding the self-evaluation requirement, no agency final rules will be approved until the matter in question has been resolved. We were requested not to publish a final rule until that time.

To date, no further action has been taken concerning publications of the final rule since we have received no notification from HHS that the issue with OMB has been resolved.

OFFICE OF ASSISTANT SECRETARY, TERRITORIAL AND INTERNATIONAL AFFAIRS

Attached are three 1981 summary reports from: (1) The Trust Territory of the Pacific Islands; (2) American Samoa; and (3) Guam.

THE TRUST TERRITORY OF PACIFIC ISLANDS (TTPI) 1981 REPORT ON AGING ACTIVITIES

As the termination of the U.N. Trusteeship approaches, the TTPI is transferring some program responsibilities to the three new governments. Problems encountered in 1981 stemmed primarily from the need for additional training of staff in each of the new governments. Consequently, a prime focus in 1981 is a plan for intensive training of program management staff.

The TTPI is providing the following summary of its 1981 programs and opportunities for elderly, with funding from the U.S. DOL and the DHHS, the Trust Territory Office on Aging (TTOOA) sponsored programs in each of the three governments which have emerged within the TTPI: The Republic of Palau, the Government of Marshall Islands, and the Federated States of Micronesia (FSM).

Each of these governments have aging programs and elderly councils to assist in assessing elderly needs and delivering services. The interaction of traditional and elected leaders, aging program personnel, and the elderly themselves resulted in the identification of the concerns of elderly and the development of programs which acknowledged those concerns through supporting existing services or supplying needed resources not currently available in 1981.

Employment opportunities were provided for a total of 388 elderly, many of whom worked as cultural advisers, others contributed to their communities as carpenters, cooks, homemakers, beautification workers, and senior center recreation staff. The Marshalls and the FSM States elected to sponsor nutrition programs to improve the health and general well being of the elderly. Congregate meals were served in multipurpose senior centers to a total of more than 800 who were able to gather for food and fellowship. Home-delivered meals were provided to 400 homebound elderly. In the Federated States of Micronesia homes of 66 elderly were renovated in order to provide a safer, healthier, and more comfortable living environment for frail elderly. To provide improved comfort, health, and independence of more than 1,500 disabled elderly, the Geriatric Home Health Service afforded nursing and dental care, rehabilitation therapy, homemaker assistance, family counseling, health education and appropriate treatment, or referrals for improved access to services and increased interagency cooperation from the information and referral services given nearly 1,000 elderly. Transportation and legal assistance were provided to 600.

SUMMARY OF 1981 PROGRAMS FOR THE AGING REPORTED BY AMERICAN SAMOA

During fiscal year 1981, American Samoa's program for the aging consisted of providing supplemental nutrition through cold and hot meals, providing transportation for those otherwise incapable of absorbing such costs, providing legal services for the needy elderly, providing certain health aids, and renovations to homes occupied by elderly people. Though the program has been multifaceted, it has been necessarily modest due to the limited resources available to American Samoa. The programs that have been implemented, however, are considered essential to meet the minimal needs of the eligible elderly people in American Samoa.

Projections: Demographic data indicated the elderly population in American Samoa is increasing at a very rapid rate. The increase is placing considerable stress on our very limited fiscal and human resources. Critical issues in aging have thus become more difficult to address and more complex to resolve.

Economic security: The Territorial Administration on Aging has identified and operated under a primary objective of developing local, State, and Federal policy recommendations affecting the income of elderly Samoans. The diminishing amount of public funds available for financing programs for the elderly has created an urgency in developing equitable distribution methods. Inflation was recognized as the elderly's greatest barrier to attaining economic security, a barrier which is rapidly escalating and creating a situation where poor and middle-income older persons alike are experiencing increasingly greater difficulty in meeting essential needs.

Total expenditures for fiscal year 1981: $1,620,660.

SUMMARY REPORT FROM GUAM ON AGING ACTIVITIES FOR 1981

The 1981 activities for the elderly reported by Guam include the following:

(1) Granting of a request by the staff of the 1981 White House Conference on Aging (WHCOA) made by the Pacific Islanders to have their own Mini-Conference on Aging on Guam, March 18–19, 1981, to become involved in the formulation of national policy for the aging and the aged. Participating governments included Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, Trust Territory of the Pacific Islands, and the Federated States of Micronesia.

(2) On September 3, 1981, at the conference of the Association of Pacific Basin Chief Executives the same Pacific governments officially incorporated themselves under the name of the "Pacific American Territories on Aging Council (PATAC)." At this conference a resolution was passed requesting endorsement, support, and commitment from these Pacific governments to PATAC's goals "to assist, formulate, and enhance the voice of the Pacific governments in policies relating to the aging and the aged."

(3) PATAC seeks policy changes on issues concerning health care, housing, and transportation:

(A) The proposed policy recommendations are, "to modify Federal legislation and attendant regulations to improve health care delivery systems so that these systems are more relevant to meet specific needs of our elderly and clearly define the Older Americans Act and applicable regulations to include and support the comprehensive health systems often inadequate or absent in respective areas."

(B) With regard to housing, PATAC "requests that Federal policymakers be more sensitive to the traditional extended family system among Pacific Islanders, and that Island planners be given the option to formulate the best possible programs to meet the elderly's needs and to utilize and maintain the familial cultural ties."

(C) PATAC recommends that "special consideration must be given to develop alternative modes of transportation compatible with the Archipelago of these Pacific Islands."

(4) "PATAC recommends that the Administration on Aging within the U.S. Department of Health and Human Services draft and forward to the U.S. Congress proposed legislation that would amend the Older Americans Act to provide a special provision or introduce a new and separate title for the Pacific Island elderly."

(5) PATAC strongly supports the following solutions regarding funding: "(a) that authorization be granted for utilization of existing funding sources under the act (the Older Americans Act) to provide constructive program implementation for meaningful and relevant services responsive to Pacific Island needs, (b) that the Administration on Aging establish effective interagency agreements with other national agencies whereby unused funds committed to a program for the elderly in one agency that is not being implemented on the local level may be transferred to another agency which could better utilize existing funding, and (c) that the Pacific Basin governments identified with PATAC be given priority on the reallotment of Federal funds under the Older Americans Act for use by other State offices on aging."

(6) The 1981 White House Conference on Aging in November-December 1981 is PATAC's vehicle to accomplish its ultimate goal concerning specific programs on aging to meet the needs of the Pacific Island elderly.

Public Health and Social Services: Division of Senior Citizens

A. Social Services

1. Access Services:

Transportation.—There is no public transportation system on Guam. Older people are provided transportation services through a private contractor utilizing privately owned vehicles. In fiscal year 1981, 525 older persons received 150,000 units of transportation services.

Information and referral.—Basic informational and referral services are obtained through a private contractor who utilize senior centers located throughout the island on focal points of services. Services of this nature numbered 4,300.

Outreach.—All services contractors conduct outreach activities. Approximately 1,500 clients were identified during the year.

2. In-Home Services:

Homemakers/Home Health Aide.—A private contractor provided these services on a daily basis to approximately 250 homebound clients.

3. Community Services:

Health Screening Services.—Health screening services were provided by local public health agency to approximately 500 elderly. The purpose of the health screen were to determine types of chronic conditions most prevalent and medical services utilized and available.

Mental health maintenance.—Basic mental health education and counseling were provided through a private contractor. Twenty-six elderly were seen and given these type of services.

Legal services.—This program was recently introduced as a new program for the elderly of Guam. A local organization was incorporated this year, has been sanctioned by the National Legal Services Corporation and has recently received funds from them. In addition, funding under Title 111–B was awarded under contract to this organization to provide legal advice and representation to older people who have legal problems that are civil in nature.

Local cultural program.—This program is offered once a week to allow older people on Guam to engage in activities that are culturally enriching.

B. Nutrition Services

Congregate meals.—This service program is provided through a private food catering company that delivers and serves approximately 340,000 meals to all congregate sites 5 days a week.

Home delivered meals.—This service program is provided through a private contractor and delivers approximately 140,000 meals to homebound older people.

C. White House Conference on Aging Forums

In conjunction with the 1981 national White House Conference on Aging Activities, public forums were conducted over a 4-month period at 16 senior centers in order to afford a 'grassroots' involvement on issues and problems of older people on Guam.

D. Funding

The Guam State Agency on Aging received AoA title III grants for fiscal year 1981 as follows: State agency administration, $75,000; Social services, $627,700; Congregate meals, $730,125; and Home delivered meals, $137,125.

Title IV–A training and education grant in the amount of 15,000 (the Guam State Agency was able to maximize the Federal allotments for fiscal year 1981).

Problems:

Problems facing older people on Guam are multifaceted. The most pervasive are: Health maintenance; income maintenance; lack of a comprehensive and coordinated social services delivery system; reliability of Federal laws with respect to programs which affect the island; and loss of cultural identity in a multiethnic society.

NATIONAL PARK SERVICE

The National Park Service has long recognized its responsibility to provide opportunities for the Nation's citizens to participate in and enjoy the programs provided throughout its system. The 1979–81 long-term management plan clearly stated this responsibility when it said:

"Our stewardship encompasses making the national park experience available to every person through an expansion of their understanding of the resources and how they may be used and preserved. The Service must insure that the barriers are removed which keep the handicapped, the disadvantaged, the elderly, and minorities from visiting the parks. Service, in the full sense of that concept, includes information, education, accessibility to all, security, comfort and convenience, and programs which give visitors the opportunity to enhance their understanding of their heritage, environment, and themselves."

Certainly this statement emphasizes our commitment to providing improved access to and programs for the aged members of our society. Over the past few years, considerable action has taken place at the national, regional, and local park levels to fulfill this commitment. A number of our parks have developed specific programs for senior citizens. These programs include special activities such as day camps for seniors, the provision of senior centers, special tours and programs, as well as outreach efforts where park personnel go into convalescent hospitals and nursing homes to present programs usually provided at the park.

GEOLOGICAL SURVEY

One of the very distinctive strengths of the Geological Survey is its relationship with tradition and the past. Over the past 100 years the Survey has established a well-deserved reputation for excellence in earth science research. Its achievements are reflected by the men and women of science whose efforts have shaped and fostered its development. Many of these people have been Survey employees most of their lives. Among our employees are more than 350 reemployed annuitants, including three former Directors, several Assistant Directors, and many former Division Chiefs. It is recognized in the Survey that the experience which these people possess cannot be replaced. Most of them continue to be employed because they have no desire to stop the challenging work begun during their careers, and because the Survey has a need for and sincere interest in their knowledge of the organization and its mission. Their expertise is a fund from which younger employees can draw in order that their own work be enriched.

At the Geological Survey there are few programs directed exclusively toward the aging. Rather, the impact of aging is directed toward recognition and utilization of the talents of older workers. Each year in ceremonies which honor meritorious service and special achievements, there are many awards for length of service. Awards for 30 years of service have been granted to 324 Survey employees; 23 have received 50-year service awards; and two people have received 60-year service awards. The key to understanding the dedication of these people seems to lie in the awareness that in science their work continues to be useful, productive, and unique. Still active, they can build upon their past and contribute their capabilities to the future.

The only actual ongoing program which focuses directly upon aging employees is the retirement planning program operated by the Office of Program Evaluation and Employee Development. Retirement planning seminars are given approximately four times a year (more often as needed) in an effort to provide employees who are contemplating retirement with a sufficient knowledge of retirement concerns to enable them to prepare adequately for retirement. Courses usually include discussions of personal attitudes and adjustments in retirement, financial planning, social security, civil service annuity benefits, and health maintenance. Courses are well attended and considered by participants to be highly successful.

In summary, it is the policy of the Geological Survey to look upon the aging employee from a utilitarian point of view. Rather than a burden to be contended with, the experienced scientific, technical, and other men and women of the Survey are a commodity upon which we build.

BUREAU OF MINES

Because our work is scientific, we employ comparatively large numbers of engineers and physical scientists. As these types of jobs are often highly specialized, we are frequently able to capitalize on the advanced level of skills and expertise which older persons in these fields are able to bring to the Bureau. The Bureau regularly uses reemployed annuitants and currently employs in excess of 80 people over the age of 65. Of these, more than 20 are above 70 years of age.

For those persons who are eligible and interested in retirement, the Bureau has cosponsored seminars in cooperation with the Internal Revenue Service, the Social Security Administration, the Veterans Administration, and various local attorneys and bank officials. Individual retirement counseling is always available to those who are interested.

BUREAU OF RECLAMATION

The Bureau of Reclamation has traditionally carried out programs which provide meaningful opportunities for older Americans, principally in the areas of employment and recreation.

The Bureau's employment policy stresses equality of opportunity for all Americans. Qualifications requirements are based on the required skills, knowledge, and abilities for each position. This can prove beneficial to senior citizens who possess long and extensive experience in the Bureau's water resource programs. Physical standards are kept at the minimum level needed for safe and effective performance. The Bureau employs several older persons in a broad spectrum of occupations. We also utilize retired individuals in consultant roles and as members of boards and commissions.

The Bureau has participated in surveys to determine physical barriers which prevent or discourage access to facilities and offices. Facilities are designed and modified where possible to meet the needs of handicapped persons, a large percentage of whom are senior citizens.

Opportunities are also available at Bureau facilities for water-oriented leisure activities such as fishing, boating, and camping which traditionally attract retired citizens and other older Americans.

The Bureau of Reclamation is committed to continue its efforts in providing opportunities beneficial to all persons including the aging population.

BUREAU OF INDIAN AFFAIRS

The Bureau of Indian Affairs does not receive a specific appropriation for an aging services or assistance program. Tribes wishing to operate an aging services program normally must look to other resources for funding for this purpose. The basic resource at present is title VI, Older American Act, which provides for grants to tribes for specific aging services activities.

The Bureau's position in this regard is that Bureau of Indian Affairs social services *grant assistance* funds (funds appropriated for general welfare assistance, child welfare assistance, and miscellaneous assistance) are not requested, justified, or appropriated for this purpose. These funds are appropriated by the Congress to meet the individual grant assistance needs of Indian clients meeting eligibility criteria for social services and welfare assistance as provided in 25 CFR 20.

This position does *not* preclude use of these grant assistance funds for those components in a tribal aging services contract which provide the kinds of assistance for eligible clientele normally funded by social services grant assistance monies, e.g., custodial care for adults which is essentialy that nonmedical care and protection provided to an eligible client when, due to *age*, infirmity, physical, or mental impairment, that client requires care from others in his or her daily living. This care may be provided in the most appropriate nonmedical setting, including the client's home, an institution, or other group care setting.

In addition to requesting an annual appropriation for *grant assistance*, the Bureau also requests an annual appropriation of funds for *social services administration*, i.e., "all other social services." These particular funds are utilized to, (a) administer the grant assistance program, (b) provide counseling services to social services clientele, and (c) assist tribes in development of social services programs. It is the Bureau's position that this appropriation for social services administration, i.e., "all other social services", provides budgetary authority to assist tribes to *develop* aging services programs. In this latter regard, the tribes may "band" or prioritize Bureau social services *administration* funds at the agency-tribal level so that these funds may be utilized for aging services program development. That "banding" or prioritization procedure would essentially result in the tribe shifting available funds from a low priority activity to a higher prioritized activity. The procedure does not provide additional money but merely shifts money from one use to another.

ITEM 9. DEPARTMENT OF LABOR

FEBRUARY 22, 1982.

DEAR MR. CHAIRMAN: Enclosed is a summary of the programs and activities of the Department of Labor for 1981 related to aging.

Described in the report are programs administered by the Employment and Training Administration, the Employment Standards Administration, and the Pension and Welfare Benefits Program.

I trust this information will be of assistance to you in preparing your report, "Developments in Aging."

Sincerely,

RAYMOND J. DONOVAN, *Secretary.*

Enclosure.

EMPLOYMENT AND TRAINING ADMINISTRATION PROGRAMS

The Employment and Training Administration has responsibility for providing or administering employment, training, and related services for the Nation's older citizens through a part-time community service employment program, comprehensive employment and training, and the employment service program.

The extent of the increased need to assist older workers to obtain jobs is related to a number of trends in our society:

—The difficulty older workers experience in obtaining jobs because of such factors as personnel policies, obsolete skills, limited training opportunities, and lack of confidence.

—The impact of inflation on older workers because of increasing prices, fixed annuity incomes, and inadequate retirement income.

—The real and anticipated impact of funding problems of retirement income systems.

—The increasing number of proportion of older people, resulting from declining birth and death rates.

—The high incidence of poverty among older people (the Census Bureau reports over 8 million people 55 and over are classified as poor or near poor).

In order to provide for the needs of the elderly, the Department of Labor has provided support for the activities that are discussed in this report.

HIGHLIGHTS OF 1981 EMPLOYMENT AND TRAINING ADMINISTRATION PROGRAM

In 1981, the Senior Community Service Employment Program (SCSEP) supported 54,000 positions, with an appropriation of $277.1 million.

Almost 24,000 people, aged 55 years and over, were enrolled in CETA title II/B/C during fiscal 1981.

In fiscal year 1981, the State employment service agencies placed 315,498 individuals age 45 and over in jobs, or more than 44 percent of all older workers referred to job openings.

Of the 498,811 veterans age 45 and over who applied for employment assistance at State employment agency local offices, 91,739 (more than 18 percent) were placed in jobs, 49,681 were counseled, and 5,911 were referred to training programs.

The Employment and Training Administration's Office of Research and Development (ORD) continued to conduct a program of research, experimental and demonstration projects dealing with middle-aged and older workers. These projects are listed under Research and Development in this report.

Pursuant to the mandate of section 308 of CETA, the Department of Labor awarded a total of $2 million to four national nonprofit organizations to develop and administer job training programs for low-income persons 55 years of age or older. These projects terminated during September of 1981. Similar projects will be undertaken during fiscal 1982, but emphasis will be placed on private sector involvement.

SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM

The U.S. Department of Labor administers the Senior Community Service Employment Program (SCSEP). This program, authorized by title V of the Older Americans Act, offers subsidized part-time employment to low-income persons age 55 and above. Although potentially almost 8 million older workers are eligible for this program, the number is much smaller due to health and other reasons. Nevertheless, it is safe to say SCSEP serves less than 1 percent of those eligible.

Program participants work an average of 20–25 hours a week in a wide variety of community service activities and facilities including day care centers, schools, hospitals, senior centers, and beautification, conservation, and restoration projects. In addition to subsidized community service jobs, SCSEP participants receive yearly physical examinations, personal and employment-related counseling, job training and, in some cases, referral to unsubsidized jobs.

The fiscal year 1981 SCSEP appropriation supports 54,200 positions, with an appropriation of $277.1 million. This represents an additional 1,950 positions over the previous fiscal year. State governments again received 55 percent of the new positions. The accompanying table shows SCSEP performance for the July 1, 1980–June 30, 1981 program year.

Senior Community Service Employment Program—Performance for the 1980-81 Program Year (July 1, 1980 to June 30, 1981)

Funding	$258,324,000
Enrollment levels:	
Authorized positions established	52,250
Unsubsidized placements	5,900
Summary of characteristics—persons actually enrolled (6/30/81) percent:	
Sex:	
Male	33
Female	67
Education:	
8th grade and under	36
9–11 grade	22
High school graduate or equivalent	28
1–3 years college	10
4 years of college and above	4
Veteran	9
Ethnic group:	
White	68
Black	21
Hispanic	6
American Indian/Alaskan	2
Asian/Pacific Islands	3
Economically disadvantaged:	
Poverty level or less	86
Age:	
55–59	20
60–64	28
65–69	27
70–74	16
75 and over	9
Area of community service in which program participants were employed:	
Services to the general community	51
Education	12
Health/hospitals	4
Housing/Home rehabilitation	2
Employment assistance	1
Recreation, parks, and forests	9
Environmental quality	2
Public works and transportation	4
Social services	10
Other	7
Services to the elderly	49
Project administration	3
Health and home care	6
Housing/home rehabilitation	3
Employment assistance	1
Recreation/senior citizens	9
Nutrition programs	12
Transportation	3
Outreach/Referral	9
Other	3
Average hourly wage	$3.42

COMPREHENSIVE EMPLOYMENT AND TRAINING PROGRAMS AND PUBLIC SERVICE EMPLOYMENT PROGRAMS

Persons in all working age groups participate in activities under the Comprehensive Employment and Training Act (CETA), which provides for comprehensive employment and training programs and public service employment.

The public service employment program was phased out during fiscal year 1981.

One of the changes in the statute was a major reordering of programs under different titles. The following table indicates the numbers of persons in the upper age groups who participated in comprehensive employment and training programs (title II–B/C) and public service employment (II–D and VI) during fiscal 1981.

CETA ENROLLMENT TABLE, FISCAL YEAR 1981

Item	Total	Percent	Title IIB/C Number	Title IIB/C Percent	Title IID Number	Title IID Percent	Title VI Number	Title VI Percent
Total participants	1,601,000		1,041,000		360,000		200,000	
45 to 54 yrs	82,900	5.2	43,700	4.2	24,800	6.9	14,400	7.2
55 yrs and over	49,900	3.1	23,900	2.3	16,200	4.5	9,800	4.9
Total, over 45	132,800	8.3	67,600	6.5	41,000	11.4	24,200	12.1

CETA, has reauthorized in 1978, and implementing regulations, provide a strengthened focus on the employment problems of older workers. Title II specifically provides that the Secretary of Labor shall insure that prime sponsors' plans provide the details of the specific services to be provided to individuals who are experiencing severe handicaps in obtaining employment, including those who are 55 years of age and older. Title III provides broad authority for research and training policies and programs to focus on providing older workers a more equitable share of employment and training resources to reflect their importance in the labor force.

The current CETA regulations are designed to enhance the effectiveness of CETA programs. Major emphases include targeting services to persons most in need and providing equitable services to significant segments of the eligible population (age, race, sex and national origin groups); ensuring comprehensive planning and delivery through coordination of the various employment and training activities; focusing on the transition of participants into unsubsidized employment; and providing for improved management control to ensure the integrity and efficiency of the program and to prevent program fraud and abuse.

CETA National Programs

On April 1, 1977, the Department of Labor provided the Administration on Aging with CETA discretionary funds to continue 15 grants for older worker employment projects which were originally authorized under Title X of the Public Works and Economic Development Act. These projects were later administered and funded by the Employment and Training Administration through direct grants.

During 1978, as many as 5,300 persons were employed in the program. However, the Department has encountered a gradual reduction in the number of enrollees through a transfer of enrollees into Title V of the Older Americans Act or into unsubsidized jobs. Currently, about 1,700 persons are working in the programs. The remaining participants who do not transfer into other jobs or programs will be supported until December 30, 1981, after which time the program will terminate.

CETA Section 308 Programs

CETA section 308 authorized programs to facilitate increased labor force participation of low-income persons age 55 and over.

Pursuant to the mandate of section 308 of CETA, the Department of Labor awarded a total of $2 million to four national nonprofit organizations to develop and administer innovative and replicable job training programs for low-income persons 55 years of age or older. The program's intent was to provide low-income, unemployed or underemployed older workers with skills to obtain permanent unsubsidized employment or training to improve skill levels and career opportunities, as well as address specific needs of individuals who have not been in the labor force for a number of years. These projects terminated during September 1981. Similar projects will be undertaken during fiscal year 1982, but emphasis will be placed on private sector involvement. Approximately $500,000 will be used for this purpose.

THE FEDERAL-STATE EMPLOYMENT SERVICE SYSTEM

Background

The national network of public employment service local offices created by the Wagner-Peyser Act of 1933, as amended, is the primary delivery system for comprehensive employment assistance to middle-aged and older jobseekers. Services include employment counseling, occupational testing, job development, labor market information, job placement, and referral to training and employment programs administered by State and local governments. Applicants in need of assistance beyond the scope of public employment service responsibility, such as vocational rehabilitation or veterans' benefits information, are referred to the appropriate service provider.

Although the unemployment rate for middle-aged and older workers is lower than for the younger age groups, the duration of unemployment experienced by mature men and women who lose their job tends to increase with age. The Age Discrimination in Employment Act (ADEA) of 1967, as amended, recognizes this trend in its coverage of most workers who are at least 40 years of age but less than 70. For purposes of recordkeeping and statistical reporting, the employment service uses age 45 as a reference point for the term "older workers."

Fiscal 1981 Accomplishments

In fiscal year 1981, the State employment service agencies placed 315,498 individuals age 45-and-over in jobs, or more than 44 percent of all older workers they referred to job openings. The 48,408 older individuals placed as a result of job development contacts represented over 15 percent of all applicants age 45-and-over placed in jobs. Ten percent of all older applicants were referred to other agencies for services to enhance their employability. Of the 498,811 veterans age 45-and-over who applied for employment assistance at State agency local offices, 91,739, or more than 18 percent, were placed in jobs, 49,681 were counseled, and 5,911 were referred to training programs.

Thirty-five State employment service agencies reported participation in the twenty-second annual observance of "National Employ the Older Worker Week" sponsored by the American Legion. The State agencies collaborated with American Legion Posts, State and Area Agencies on Aging, Comprehensive Employment and Training Act (CETA) prime sponsors, Senior Community Service Employment Program (SCSEP) grantees, and other public and private organizations concerned with expanding career and employment opportunities for middle-aged and older workers. Governors and local officials in 32 States are known to have signed proclamations, and media coverage was provided by over 690 newspapers, 650 radio stations and 250 commercial and cable television stations.

The U.S. Employment Service collaborated with the Office of National Programs for Older Workers, Employment and Training Administration, in the development of a "Technical Assistance Guide" (TAG) designed to encourage the utilization of specially-trained SCSEP enrollees as "Older Worker Technicians" in employment and training programs. Guidelines contained in the TAG are generally based on results of an ETA-funded pilot project, "Referral/Employment Network for Elderly Workers" (RENEW), conducted by the Preretirement Planning Center, Washington, D.C., with the cooperation of six State employment service agencies which served as demonstration sites. Sixteen State employment service agencies have reported the use of paid part-time and volunteer personnel to augment regular local office services to older jobseekers.

OLDER WORKER SERVICES TREND DATA

Services to individuals by State employment service agencies	Individuals served (age)			
	Total all ages	45 and over	55 and over	65 and over
New applicants and renewals	16,501,698	2,063,374	803,702	121,171
Individuals referred to job openings	7,461,302	711,752	258,189	41,948
As percent of new applicants and renewals	45.2	34.5	32.1	34.6
Individuals placed in a job	3,728,017	315,498	117,652	23,164
As percent of individuals referred to job openings	50.0	44.3	45.6	55.2
As percent of new applicants and renewals	22.6	15.3	14.6	19.1
Individuals counseled	1,096,495	126,099	43,379	4,928
As percent of new applicants and renewals	6.6	6.1	5.4	4.1
Individuals placed after counseling	244,555	21,431	7,155	902
As percent of individuals counseled	22.3	17.0	16.5	18.3
As percent of new applicants and renewals	1.5	1.0	0.9	0.7
Individuals tested (aptitude, proficiency and other)	819,058	60,648	16,522	1,726
As percent of new applicants and renewals	5.0	2.9	2.1	1.4
Individuals referred to training	1,370,436	205,210	81,691	8,246
As percent of new applicants and renewals	8.3	10.0	10.2	6.8
Individuals referred to supportive services	1,964,261	281,629	108,036	13,063
As percent of new applicants and renewals	12.0	13.6	13.4	10.8
Individuals placed as a result of job development	485,667	48,408	48,175	3,476
As percent of new applicants and renewals	2.9	2.3	2.3	2.9
As percent of individuals placed	13.0	15.3	15.4	15.0

Source: U.S. Department of Labor, Employment and Training Administration, U.S. Employment Service.

RESEARCH AND DEVELOPMENT

The Employment and Training Administration's Office of Research and Development (ORD) conducts a program of research, experimental and demonstration projects to improve and/or develop new employment, training and income maintenance programs, policies and initiatives. The program includes institutional grants to enable universities to conduct a research and to train specialists in the employment and training field, as well as grants to support doctoral dissertation research and post-doctoral studies to develop new approaches to solve employment and training problems or to contribute to policy formulation. The combination of low fertility rates and decreased mortality rates is leading to increased "aging" of the population of the United States. Population projections indicate a rise in the median age as well as increased proportions in the upper age groups.

Recently completed and ongoing research and development projects concerned with middle-aged and older workers include:

A. Recently Completed Projects

1. Retirement experience of nonsupervisory personnel

This study focuses on the retirement experiences of non-supervisory personnel who retired between 1968 and 1978 from three large American corporations (a large manufacturer, a chain store, and a public utility). It deals with the decision to retire, planning for retirement, expectations about retirement, and post-retirement work experience. The findings are compared with findings of an earlier study of managerial, professional and technical workers who retired from the same corporations. The major findings for non-supervisory personnel indicate that 24 percent retired because of mandatory retirement policies. Reasons most frequently given for early retirement were poor health (for men) and "had worked long enough" (for women). About 25 percent of the respondents had some type of work experience after retirement and most were well satisfied with their post-retirement jobs. The most important problems after retirement were inflation, own health, and spouse's health.

2. Longitudinal study of the labor market experience of men

The fifth report on the National Longitudinal Surveys (later described under Ongoing Projects) deals with a ten-year follow-up of men initially surveyed in 1966 when they were 45–59 years of age. Among the findings are the following: (1) mandatory retirement forced only a small minority of men out of jobs; (2) poor health forced eight times as many men out of jobs as mandatory retirement; and (3) a larger proportion of blacks than whites left the labor force because of disability, but this difference is explained by the difference in earnings relative to disability benefits. Although decreasing, race discrimination caused labor market disadvantages for blacks. Most men who retire for reasons other than health are happy in retirement, and most middleaged and older men who remain in the labor force enjoy relatively favorable positions.

The Department of Labor has published a series of monographs based on interviews with the men, and a book was recently published on the labor market related experiences of the 45–59 year-old cohort during the period 1966–1976. In 1980, a fact book was released on work and retirement data from the surveys, including information on the man's wages, employment status, education and training, health, occupation, job mobility, work attitudes, marital and family characteristics, and financial situation when approaching and entering retirement.

3. Social security and the labor supply of older men

This study estimated the effects of Social Security and the associated earnings test on the retirement rates of men over 62. An analysis of National Longitudinal Surveys of men over 62. An analysis of National Longitudinal Surveys data indicated that changes in the earnings test between 1970 and 1974 had no measureable effect on retirement behavior. The study results also suggest that eliminating the earnings test will not increase labor supply but will increase the net cost to the government of Social Security.

4. Research and development strategy on the employment-related problems of older workers

This study, completed in 1978, includes a systematic examination of all relevant older worker data, a review and evaluation of ongoing older worker programs, and an analysis of older worker policy issues and priorities. A major objective was to identify knowledge gaps and innovative programmatic approaches which might be addressed in research and development projects as a basis for improving programs and policies directed towards the employment-related problems of older persons. The study is expected to provide guidance for older worker research and development projects over the next several years.

5. Program participation of elderly Hispanic Americans

A survey of 600 elderly Hispanic Americans in Riverside County, California, to study their participation in employment and training programs under the Comprehensive Employment and Training Act (CETA) and the Older Americans Act. The major findings of the survey are that elderly Hispanic Americans have a low participation rate in these programs and that their knowledge or awareness of the programs is minimal.

6. Demonstration of development and testing of job sharing (project JOIN)

A project to develop and test job sharing in the Wisconsin Civil Service system for persons wanting to return to work part-time, for persons planning to retire, and for full-time employed persons who prefer to work part-time. The study was designed to measure the productivity of those in conventional work situations and to measure the impact of creating less-than-full-time jobs on the balance of the work unit in which persons sharing jobs were located. The study findings indicated that job sharing can be implemented successfully, and can result in benefits to the employing organization as well as to the workers.

7. Paper on socio-economic policies and programs for the elderly

In response to a request from the Organization for Economic Cooperation and Development (OECD), a paper was prepared on socio-economic policies and programs for the elderly. The paper describes and analyzes policy options and related problems, with emphasis placed on employment and related social programs and policies conducive to the labor market participation and social and community involvement of the elderly.

8. Utilization of retired teachers as a supplemental educational resource

A study to determine the feasibility of using retired teachers to make a significant impact on the solution of educational problems in the District of Columbia through the exercise of their lifetime skills, without undercutting the incomes or ambitions of younger teachers. The results indicate that a demonstration "emeritus teachers" project can be undertaken in the District of Columbia with a good chance of success. Such a demonstration project is underway.

B. Ongoing Projects

1. National longitudinal surveys (NLS)

Since 1966, the Department of Labor has funded the National Longitudinal Surveys (NLS), tracing the education, training, and labor market experiences of selected population groups at critical transition stages in working life, specifically, youth entering the labor force, women reentering the labor force, and men in their preretirement and retirement years. The last group consists of 5,000 men who were aged 45–59 when first interviewed 15 years ago. The 15th year interviews with men were conducted in July–September 1981.

2. Demonstration of development and testing of alternative patterns for older workers

A project to develop and test a variety of employment options in the Wisconsin State Civil Service for persons approaching retirement age (55) and for those who have already retired but would like to reenter the workforce in an option other than the traditional 5-day, 40-hour week. Options include various part-time and full-time work schedules. Analyses will be conducted with respect to factors such as the effects on income, job satisfaction, morale, health and productivity; and comparisons of job option participants and a matched standard work-week group. A major objective is to develop a prototype preretirement employment policy for the State of Wisconsin with the model structured so that its components could be used by other State and local governments.

3. Retired teachers as tutors

A project to demonstrate and assess the effectiveness of utilizing the services of retired teachers as volunteers in a program to improve the reading and math skills of elementary school pupils in the District of Columbia. The project is designed to determine the degree to which retired teachers gain satisfaction and a sense of accomplishment by utilizing their lifetime sklls, as well as to measure the effectveness of tutoring in improving the performance of students who need remedial assistance.

4. Early retirement and the labor market dynamics of older workers

A doctoral dissertation grant to study early retirement and its effects, with the objective of developing information on unemployment compensation, Social Security, and other retirement areas.

PENSION AND WELFARE BENEFIT PROGRAMS

Pension and Welfare Benefit Programs (PWBP) is a part of the Department of Labor's Labor-Management Services Administration. It is responsible for enforcing the Employee Retirement Income Security Act (ERISA). PWBP's primary responsibilities are for the reporting and disclosure and fiduciary provisions of the law.

Employee benefit plans, generally maintained by employers or by employers and unions, must meet certain standards set forth in ERISA. These standards are designed to insure that an employee actually will receive the benefit promised under the plan. ERISA applies only to private sector plans.

The requirements of ERISA differ according to whether the benefit plan is a pension plan or a welfare plan. Both pension plan and welfare plans must comply with certain provisions of ERISA governing reporting and disclosure to the government and to participants (title I, part 1) and fiduciary responsibility (title I, part 4). Pension plans must comply with additional ERISA standards (contained in both title I, parts 2 and 3, and title II) including who must be allowed to be a member of a plan (participation), when a participant's right to a benefit becomes nonforfeitable (vesting), and how the employer is to finance benefits offered under the plan (funding).

The Departments of Labor and Treasury have responsibility for administering the provisions of title I and title II, respectively, of ERISA. The Pension Benefit Guaranty Corporation (PBGC) is responsible for administering title IV, which establishes an insurance program for certain benefits provided by specified ERISA pension plans.

REPORTING AND DISCLOSURE STANDARDS

ERISA requires that plans disclose to participants and report to the Federal government information about plan provisions and financial status. Certain plans must submit an annual report. The report is a financial statement; defined benefit plans must also submit a certified actuarial report. The report generally includes a statement of plan assets and liabilities, a statement of the transactions involving conflict of interest situations and other information regarding the administration of the plan. Annual report forms are simplified for small plans, and a number of paperwork reductions have been instituted since ERISA's passage.

The annual report is submitted to the Internal Revenue Service (IRS) and shared by the ERISA agencies. This information is used for enforcement and research. The plan administrator submits the annual report to the IRS and furnishes participants and beneficiaries with a summary of it, called the summary annual report (SAR). Plan administrators must also furnish participants (and the Department of Labor) with a summary plan description (SPD) written in a manner calculated to be understood by the average person. The SPD contains a description of benefits, the requirements for eligibility and procedures for presenting claims for benefits. In addition, participants may request, or in some cases, must receive a statement of their individual benefits. Reduction of unnecessary paperwork, to the extent consistent with assuring necessary information is submitted to enforce the law, was a top priority in 1981 and will continue to be so.

MINIMUM STANDARDS FOR PARTICIPATION AND VESTING

The IRS, for the most part, enforces the ERISA minimum standards. ERISA sets forth certain standards regarding the age and service requirements which an employee can be required to have completed before being allowed to participate in the employer's pension plan. The basic rule is that an employee cannot be denied membership in the plan, merely on account of age or service, if he or she is at least 25 years old and has worked for the employer for one year.

Certain other ERISA provisions govern when a plan participant must gain a nonforfeitable right to that portion of the retirement benefit provided by the employer's contributions to the plan. (The participant's own contributions are always nonforfeitable.) In this regard, the plan must provide that an employee gains a nonforfeitable right to this portion of his or her retirement benefit according to a schedule which is not less generous than one of the four set forth in ERISA. ERISA also contains rules on the rate at which participants must be allowed to "accrue" a benefit, i.e., the rate at which they are considered to have "earned" a portion of their ultimate retirement benefit. These standards basically are relevant to pension plans which provide participants a certain periodic payment upon retirement.

MINIMUM FUNDING STANDARDS

ERISA sets forth certain rules regarding the financing of pension plan benefits that basically apply to those plans which promise participants a defined periodic payment upon retirement. In plans of this type, the employer's contributions are determined actuarially (i.e., using certain assumptions concerning mortality, interest, turnover, etc.) to calculate how much is needed in order to insure sufficient funds to provide for the benefits promised by the plan. ERISA provides rules governing what sorts of actuarial assumptions and funding methods are appropriate and establishes penalties for failure to comply with these standards. These funding rules are enforced by the IRS.

FIDUCIARY STANDARDS

ERISA sets certain standards regarding the investment and utilization of plan assets with which fiduciaries of employee benefit plans must comply. These standards include that plan assets be invested "solely in the interest" of plan participants and beneficiaries and that plans be maintained for the exclusive benefit of the participants and their beneficiaries. ERISA provides that fiduciaries adhere to standards regarding the safeguarding and diversification of plan assets that would be followed by a "prudent" investor. ERISA also sets forth certain rules governing activities that (unless specifically exempted) may not be carried out by certain individuals and groups (including fiduciaries) who, because of having a potential conflict of interest with the plan, might cause the plan to operate in the interests of themselves rather than in the interests of the plan participants and beneficiaries. These activities are known as "prohibited transactions," and persons who violate them are subject to a tax imposed by the Internal Revenue Service.

Civil actions may be brought by the Secretary or plan participants and beneficiaries for a breach of fiduciary duty. The Department places great emphasis on enforcing these fiduciary provisions. In fiscal year 1981, it restored $33.2 million in plan assets (it also recovered over $10 billion in benefits for participants).

PLAN TERMINATION INSURANCE

Title IV of ERISA establishes a benefit insurance program administered by the PBGC, an independent nonprofit entity with a board of directors consisting of the Secretaries of Labor, Commerce, and Treasury. This insurance program is applicable only to certain pension plans which promise a defined benefit upon a participant's retirement. Employers who maintain these covered plans are required to pay a per-participant premium to the PBGC to finance this coverage.

The guarantee program itself differs according to whether the plan in question is a single-employer plan or one maintained by more than one employer. In the case of a single-employer plan, the PBGC will guarantee, to a certain prescribed level, the payment of a participant's nonforfeitable benefit in plans which terminate with insufficient assets to meet their obligations to pay these benefits. In the case of a multi-employer plan, the PBGC also guarantees benefits, at a prescribed level lower than in the single-employer situation. In this case, however, it is the inability of the plan to pay participants their guaranteed amount rather than termination that triggers financial assistance.

RESEARCH AND DEVELOPMENT

PWBP conducts coordinated program of research through contracts and inhouse studies. The research program develops data on employee benefit plans which can be used as the basis for program modifications or policy decision. It also analyzes economic issues related to retirement decisions and income.

The following studies were initiated in 1981:

(1) A study to determine the industrial demand for retirement age workers.

(2) A study to analyze the effects of inflation on pension benefits.

(3) A study on the economics of pensions.

(4) A study to determine the optimal ways to index pensions.

(5) A study of retirement models underlying individual labor supply and retirement decisions.

(6) Patterns of worker coverage by private pension plans.

(7) Preliminary estimates of participant and financial characteristics of private pension plans, 1977.

The following studies were completed in 1981:

(1) An Analysis of the Potential Impacts of National Health Insurance Programs on Collective Bargaining.

(2) An analysis of pension plan costs, 1972–76.

(3) Employment Related Health Benefits in Private Nonfarm Business Establishments in the United States.

(4) Employee Welfare Benefit plans and Plan Sponsors in Private Nonfarm Sector in the U.S. in 1978–79.

(5) Evaluation Study of the Impact of the Prohibited Transaction Provisions of the Employee Retirement Income Security Act.

(6) An Empirical Study of the Effects of Pensions and the Saving and Labor Supply Decisions of Older Men.

(7) Some Theoretical and Empirical Aspects of the Analysis of Retirement Behavior.

(8) Prepaid Legal Service Plans in the Employment Context: A Report of Major Characteristics and a Profile of Plans.

(9) Group Health Insurance Coverage of Private Full-time Wage and Salary Workers, 1979.

(10) Preliminary Estimates of Participant and Financial Characteristics of Private Pension Plans, 1977.

(11) Study and Analysis of Portability and Reciprocity in Single Employer Pension Plans.

INQUIRIES

PWBP publishes literature and audio visual materials which explain in some depth provisions of ERISA, procedures for plans to effect compliance with the act, and the rights and protections afforded participants and beneficiaries under the law. In addition, it deals with many inquiries from older workers. During fiscal year 1981, the National and field office staff of PWBP responded to over 120,000 inquiries from plan participants, beneficiaries and other persons interested in the administration of plans. Among the publications disseminated, the following are designed exclusively to assist the public in understanding the law and how their pension plans operate:

—What you should know about the pension and welfare law (English and Spanish versions).

—Know your pension plan.

—How to file a claim for benefits.

—Often asked questions about ERISA.

EMPLOYMENT STANDARDS ADMINISTRATION PROGRAMS

On July 1, 1979, the Equal Employment Opportunity Commission (EEOC) assumed enforcement responsibilities previously carried out by the Department of Labor under the Age Discrimination in Employment Act of 1967 (ADEA) as amended, which prohibits employment discrimination on the basis of age in private sector and State and local government employment. (The EEOC had already assumed responsibility on January 1, 1979, for enforcement of the ADEA in the Federal sector, for which the Civil Service Commission had previous jurisdiction). Under Presidential Reorganization Plan Number 1 of 1978, which made these transfers, the Department of Labor continues to be responsible for research regarding older workers (including studying the effects of the 1978 ADEA amendments) and for educational activities under the ADEA related to expanding employment opportunities for older persons.

Section 5 of the ADEA requires that the Secretary of Labor conduct an appropriate study of institutional and other arrangements giving rise to mandatory retirement. The 1978 ADEA amendments stipulated that the Section 5 study be expanded to include an examination of the consequences of the amendments which raised the permissible mandatory retirement age to 70 for most private sector and State and local government employees. Specifically, the amendments required that this study include: (1) an examination of the effect on private sector and non-federal public employment of raising the upper age limit on coverage from 65 to 70; (2) determination of the impact of raising or eliminating the current (age 70) upper age limit; and (3) examination of the effects of exemptions permitting mandatory retirement at ages 65 through 69 of tenured teaching personnel in institutions of higher education (until July 1, 1982) and of certain high policymaking executive employees. The law requires that the results of the Department's research be transmitted to the Congress in an interim report (1981) and a final report (1982).

In 1979, the Department awarded a series of research contracts to enable the Secretary to fully implement the Congressional directive in Section 5 of the ADEA for research relating to involuntary retirement and the effects of the 1978 amendments. These research projects included: (1) a national survey of employer and employee responses to the ADEA provision raising the permissible mandatory retirement age from 65 to 70 (including an examination of employer retirement, pension, and personnel policies and the retirement plans of employees); (2) a major analytical study of the labor force consequences of raising the mandatory retirement age (including estimation of the effects on labor force participation of older workers, projections of long term labor force consequences of raising and eliminating the mandatory retirement age, impact on job opportunities for younger and minority workers, employer utilization of the exemption for executive employees and institutional reasons for the establishment of mandatory retirement age standards); (3) a national survey and analytical study examining the consequences of the exemption in the law for tenured faculty members at institutions of higher education (including a national survey of universities and faculty members, analytical studies of faculty hiring and retention, and projections of the consequences of raising the mandatory retirement age); (4) a study of characteristics of older workers; (5) a study of flexible employment opportunities for older workers; and (6) a study of the legal application of the bona fide occupational qualification exemption in the ADEA.

These studies were completed in 1981 and study findings were incorporated in the interim report required by law which was transmitted to Congress in December 1981.

The findings from these research studies are being used to prepare the final report of the Secretary. This report will be transmitted to Congress in 1982.

ITEM 10. DEPARTMENT OF STATE

DECEMBER 23, 1981.

DEAR MR. CHAIRMAN: The Secretary has asked me to reply to your letter of September 10, 1981. We are pleased to submit the following information concerning developments on behalf of older persons in the Department of State during 1981. This is the first full year that the Department has been subject to the responsibilities of Public Law 96–465 of October 17, 1980 (Foreign Service Act of 1980).

The Department has long acknowledged the need to improve all forms of personnel practices that can be construed as discriminatory. A section of the Foreign Service Act of 1980, which has been called a new "Employee Bill of Rights," includes age as a ground for nondiscrimination. This new act has served to pull together efforts and achievements of past years to promote the foreign policy of the United States by strengthening and improving the Foreign Service. Secretary Haig, as have past Secretaries of State, has pledged to maintain equal employment opportunity for all employees.

Under the new act, mandatory retirement for the Foreign Service has been extended from 60 to 65 years of age, which is a significant gain for older persons. Before that time the 60 years mandatory retirement age was affirmed as constitutional by the Supreme Court. Needless to say, the morale of older Foreign Service employees has improved markedly, at the same time, the U.S. Govern ment is now benefiting by the extended years of talented and experienced service that is available.

A new position as full-time attorney-adviser has been filled, and this will enhance capabilities of our Office of Equal Employment Opportunity to serve the needs of both Civil and Foreign Service personnel, including older persons.

Thank you for the opportunity to contribute to this year's committee report on the aging.

Yours sincerely,

RICHARD FAIRBANKS,
Assistant Secretary for Congressional Relations.

ITEM 11. DEPARTMENT OF TRANSPORTATION

DECEMBER 11, 1981.

DEAR MR. CHAIRMAN: I am pleased to forward to you the enclosed report which summarizes significant actions taken by this Department during 1981 to improve transportation facilities and services for older Americans. The report is being forwarded to you in response to your letter of September 10 to Secretary Lewis, requesting information for part 2 of the committee's annual report, "Developments in Aging." Information will be submitted subsequently regarding relevant activities of the Urban Mass Transportation Administration.

If we can assist you further, please let us know.

Sincerely,

JUDITH T. CONNOR,
Assistant Secretary for Policy and International Affairs.

Enclosure.

SUMMARY OF ACTIVITIES TO IMPROVE TRANSPORTATION SERVICES FOR THE ELDERLY

INTRODUCTION

The following is a summary of significant actions taken by the U.S. Department of Transportation during 1981 to improve transportation for elderly persons.[1] The information included in the report was furnished by the Office of the Secretary and by the following operating elements of the Department: Federal Aviation Administration (FAA), Federal Highway Administration (FHWA), and National Highway Traffic Safety Administration (NHTSA). Information will be submitted subsequently regarding relevant actions of the Urban Mass Transportation Administration.

REGULATIONS

Office of the Secretary

On May 26, 1981, a Federal Court of Appeals ruled that the Department of Transportation exceeded the authority of section 504 of the Rehabilitation Act of 1973 when, in May 1979, it issued its 504 implementing regulation requiring lifts on buses and elevators in subway stations. In response to that court decision, the Department issued, on July 20, 1981, an interim final regulation rescinding these mass transit accessibility provisions and substituting a requirement that transit operators certify that they are making special efforts to provide transportation for handicapped persons. A formal rulemaking process to develop a permanent section 504 rule is underway, which will include an analysis of several hundred comments received on the interim rule.

Federal Aviation Administration

In response to a petition from the American Federation of the Blind, the Federal Aviation Administration issued an amendment to the Federal Aviation Regulations, on June 21, 1981, that provides methods by which flexible travel canes may be stored safely within reach of blind passengers. In addition, the amendment provides that the air carrier must make information available to the public regarding any procedure it establishes relating to the air carriage of persons who may need evacuation assistance. The amendment also provides that air carriers must make information on such procedures available to the public at airports which they serve.

---

[1] Many of the activities highlighted in this report are directed toward the handicapped. However, more than one-third of the elderly are handicapped and will benefit from these activities.

Federal Highway Administration

FHWA continued to monitor the States' compliance with the Department's section 504 regulation requirement that existing safety rest area facilities on the Interstate Highway System be accessible to and usable by physically handicapped persons, including wheelchair users, within 3 years of the effective date of the regulation (i.e., by July 2, 1982).

FHWA also continued to monitor State compliance with section 402(b)(1)(f) of title 23, U.S.C., which requires curb cuts a newly constructed pedestrian crosswalks, and the FHWA requirement that all new facilities on Federal-aid highways be designed to accommodate elderly and handicapped persons.

POLICIES AND GUIDELINES

Federal Aviation Administration

Investigators of aircraft accidents are continuing to feed information into FAA's Civil Aeromedical Institute computer bank on the human factors aspect of aircraft accidents and incidents. This information should prove useful to the FAA and the airline industry in the identification of special problems that are likely to be experienced by elderly and disabled persons during evacuation after airline accidents.

Federal Highway Administration

FHWA has adopted a policy that, where possible, new pedestrian overpasses and underpasses should not be constructed with grades steeper than 8.33 percent. Variations from this policy must be approved by the Washington office of FHWA.

CAPITAL ASSISTANCE

Federal Aviation Administration

The amount of $400,000 was programed for the construction of an additional elevator and several automatic doors at Washington National Airport. The amount of $450,000 is available for the installation of three passenger elevators at Dulles International Airport. Both projects are in the design phase and construction will begin in fiscal year 1983.

Under FAA's airport development aid program, Federal, State, and local funds in excess of $286 million have been obligated by airport operators for improving terminal facilities. Grant recipients are required to incorporate the requirements of the American National Standards Institute, Inc. (ANSI) specification in all projects.

Federal Highway Administration

The section 18 program provided assistance for project administration, capital assistance, and operating assistance for public transportation service in nonurbanized areas. About $73 million was obligated for such activities in fiscal year 1981. This funding helped start new transportation systems and expanded others that directly benefit the elderly.

INFORMATION DISSEMINATION

Office of the Secretary

The Department's technology sharing program cooperated with the Administration on Aging in making available the study report entitled "Improving Transportation Services for Older Americans." This two-volume report focuses on the role of area agencies on aging in providing transportation services to elderly persons.

The Department's Transportation Systems Center, in support of the technology sharing program, has completed and is disseminating summary reports on wheelchair restraint systems and the state-of-the-art in small transit vehicles. The small transit vehicle document may be purchased from the U.S. Government Printing Office.

The technology sharing program also disseminated a manual, prepared originally for the Wisconsin Department of Transportation, on a model State process for coordinating transportation services for elderly persons and other special user groups. The document is entitled "Wisconsin Manual To Coordinate Elderly and Handicapped Transportation Services in Rural and Small Urban Counties."

A summary document on transportation issues involving the elderly in the 1980's is now being finalized.

Federal Aviation Administration

FAA has distributed to all FAA regional offices a 25-minute slide presentation, with cassette sound track, which illustrates some of the problems persons with limited mobility experience in traveling through airports. This audio visual presentation, released in mid-1980, will assist airport and airline personnel in understanding problems disabled persons have when using airport terminal facilities, and offers solutions to these problems.

FAA continued to distribute "Access Travel: Airports," a guidebook listing design features facilities, and services that meet the needs of persons with limited mobility at airport terminals throughout the world.

National Highway Traffic Safety Administration

As part of the National Highway Traffic Safety Administration's national safety belt usage educational program, the National Retired Teachers Association /American Association of Retired Persons (NRTA/AARP), under contract to NHTSA, is to develop and implement a comprehensive safety belt education program for the elderly population. The program will then be distributed through existing national networks such as NRTA/AARP, the National Council on Aging, and the Retired Senior Volunteer Program.

The program will include: (1) A 30 to 45 minute presentation on safety belt usage for groups at the local level, (2) safety belt information to be included in NRTA/AARP's driver retraining program, and (3) a feature article on safety belts in "Modern Maturity" magazine and other publications aimed at the older population. NRTA/AARP will also provide public service announcements for local radio and television stations, and produce a radio program on safety belt use for "Prime Time," a 15-minute weekly public service program carried by 500 stations across the Nation.

WORKSHOPS AND CONFERENCES

Federal Aviation Administration

FAA continues to conduct cabin safety workshops for airline industry personnel. During each 3-day workshop, emphasis is given to procedures for assisting elderly and disabled persons under emergency conditions. During 1981, these workshops were attended by union and management personnel, emergency procedures instructors, engineers, pilots, and technical experts representing 22 U.S. airlines, three foreign airlines including Transport Canada. A total of 91 persons attended the seven workshops held in 1981, including a special workshop held for safety representatives from the Airline Pilots' Association.

Federal Highway Administration

Under the sponsorship of FHWA's National Highway Institute (NHI), six different training courses were conducted in fiscal year 1981 that included discussions of transportation problems of elderly and handicapped persons. These courses were presented for a combined total of 50 presentations with approximately 1,615 attendees. The courses were "Relocation Assistance Advisory Services" "Improving the Effectiveness of Public Hearings and Meetings," "Safety Design and Operational Practices for Streets and Highways" "Pedestrian Planning Procedures," "Rural and Small Urban Transit Managers' Workshops," and "Design of Urban Streets." In addition, NHI began developing a course on "Planning, Locating and Designing Safety Rest Areas" for presentation in fiscal year 1982.

RESEARCH COMPLETED

Federal Highway Administration

A three volume study entitled "Provisions for Elderly and Handicapped Pedestrians" has been completed. The study examines the pedestrian environment and makes proposals for improving the accessibility of elderly and handicapped persons. Major hazards, accident causes, and barriers experienced by elderly and handicapped persons were identified and some possible solutions were field tested. Major legislation of the last three decades is examined in detail.

Responding to a lack of planning in design and construction of the pedestrian environment, the study produced an implementation manual, "Development of Priority Accessible Networks," which presents design information and methodology for creating a barrier-free pedestrian facility.

Another completed study, "The Feasibility of Accommodating Physically Handicapped Individuals on Pedestrian Over and Undercrossing Structures," specifically determined the problems inherent in accommodating the elderly and physically handicapped on such structures. Potential solutions in terms of cost effectiveness, retrofitting, and design guidelines are offered. The sudy recommended additional design evaluation of ramp lengths and gradients which affect access and maneuverability.

RESEARCH ONGOING

Federal Aviation Administration

FAA's Civil Aeromedical Institute (CAI) continues to analyze biomedical factors associated with successful evacuation of passengers and crewmembers from aircraft during emergencies. CAI also is continuing to analyze data collected from accidents where escape has been either marginal or successful. Special emphasis is being given to the evacuation problems of handicapped travelers and those who become disoriented during the evacuation process. Results of research on the evacuation problem will be published and used in improving systems hardware, evacuation procedures, and passenger briefing methods.

Federal Highway Administration

The College of Architecture at Georgia Institute of Technology is nearing completion of a study entitled "Design Guidelines To Make Crossing Structures Accessible to the Physically Handicapped." The result of the project will be a set of criteria for use by design engineers in making all major types of pedestrian crossing structures accessible to elderly and physically handicapped persons. Laboratory and field tests utilizing handicapped and nonhandicapped subjects will provide information on effects of ramp gradient and length, friction of surface materials, and detectability. This project will also produce a user manual that will aid State and local planning and design engineers in making crossing structures accessible to a substantial proportion of elderly and physically handicapped persons.

National Highway Traffic Safety Administration

NHTSA has been working with the NRTA/AARP to identify the information needs of older drivers and to develop a training program to help them recognize and deal more effectively with the driving problems that surface with advancing age, e.g., reduced nighttime vision. NHTSA is sponsoring an evaluation of the training program, "55 Alive," in four different States. The final report, to be completed early in 1982, will be distributed to appropriate national and State agencies, groups, and associations dealing with older drivers.

Another NHTSA supported research project involves on investigation of traffic accident risk levels that may be associated with various types of heart disease, many of which are prevalent among older age groups. The results of this effort will be transformed into guidelines that State driver licensing authorities can use to establish licensing practices for heart attack victims that will minimize their accident risk and still allow them to satisfy their essential driving needs.

A driver's manual for older drivers, developed by NHTSA, contains information that prior research has found would be of special value to older drivers at time of driver license renewal. For example, older drivers need to realize that the aging process contributes to the loss in ability to process alcohol and that they may need to completely revise their expectations of its effects on their driving performance.

The "Older Driver Manual," together with two other manuals, is being field tested in the State of Nebraska. It is anticipated that the accident rates among applicants who received and used the manual will be lower because they were provided with safety information appropriate to their particular needs. If these specially tailored manuals are effective, a virtually no-cost countermeasure will have been found, which States may make available to older drivers.

DEMONSTRATIONS

Office of the Secretary

A six-State consortium that is exploring the use of simplified billings and accounting procedures for social service bus systems, including those that serve the elderly, is continuing its tests of alternative procedures. The group is finalizing a summary report of current accounting practices, and an overview report on the demonstration is already available. North Carolina, South Carolina, Massachusetts, Iowa, Michigan, and Arkansas are participating in the project, which is funded by DOT and the Department of Health and Human Services.

The DOT Transportation Systems Center is currently investigating the applicability of microcomputer technology to special services and coordinated transportation services for elderly citizens. This project, sponsored by the Office of Technology Sharing, focuses on the uses of stock microcomputers and standard software for accounting and transit management functions.

Federal Highway Administration

A study entitled "Development of Priority Accessible Networks" is being implemented in three cities: Seattle, Wash.; New Orleans, La.; and Baltimore, Md. A design manual developed under a previous contract is being used to develop access routes between destinations frequently used by elderly and handicapped pedestrians. The routes will contain various features to guide, facilitate, or otherwise aid this group of pedestrians.

URBAN MASS TRANSPORTATION ADMINISTRATION AND THE FEDERAL RAILROAD ADMINISTRATION

REGULATIONS

Federal Railroad Administration

Amtrak is continuing to make modifications to its passenger railroad stations, vehicles, and services in line with Amtrak's transition plan submitted in accordance with the Department's regulation implementing section 504 of the Rehabilitation Act of 1973. Amtrak expended $2.2 million in fiscal year 1981 for accessibility modifications and improvements to train equipment and stations.

POLICIES AND GUIDANCE

Federal Railroad Administration

Amtrak continued throughout fiscal year 1981 its systemwide policy of offering to all elderly persons a 25-percent fare discount on all one-way tickets valued above $40.

Urban Mass Transportation Administration

Grantees receiving Federal financial assistance under section 5(m) of the Urban Mass Transportation Act are required to charge elderly and handicapped persons no more than one-half of the peak hour rate when traveling during nonpeak hours.

CAPITAL ASSISTANCE

Urban Mass Transportation Administration

The Urban Mass Transportation Administration continued to make funds available under section 16(b)(2) of the Urban Mass Transportation Act to assist private nonprofit organizations in purchasing vehicles to transport elderly and/or handicapped persons. Grants and loans are provided when other mass transit facilities and services are unavailable or inappropriate. UMTA allocates roughly $25 million annually to this program.

INFORMATION DISSEMINATION

Urban Mass Transportation Administration

The following reports have been produced under financial assistance provided by the Urban Mass Transportation Administration:

"Wheelchair Securements on Bus and Paratransit Vehicles," California Department of Transportation, interim report, April 1981.

"Assessment of Low-Cost Elevators for Application and Use in Transit Stations," Transportation Systems Center, draft report, June 1981.

"Improving Communications with the Visually Impaired in Rail Rapid Transit Systems." Volume I: Solutions for Problems of Visually Impaired Users of Rail Rapid Transit, and Volume II: Information about Visual Impairment for Architects and Transit Planners, Boston College, August 1981.

"Wheelchair Securement System in Transit Vehicles, A Summary Report," prepared by Transportation Systems Center, Technology Sharing Office, August 1981.

"Relocating the Elderly: Six Cases of MARTA's Impact on People," University of Georgia, 1981.

"Transportation for the Elderly: Happy Faces on a MARTA Bus," University of Georgia, 1981.

"An Assessment of Wheelchair Lift Buses in Westchester County, New York," Polytechnic Institute of New York, 1981.

"Paratransit, Inc., Special Transportation Services in Sacramento," Crain & Associates, July 1981.

"Fixed Route Accessible Bus Service in Connecticut: A Case Study," Charles River Associates, July 1981.

In May 1981, UMTA made a presentation to congressional senior citizen interns.

CONFERENCE

Urban Mass Transportation Administration

200 operators of paratransit systems, users of paratransit services, vehicle manufacturers, representatives of public service agencies, and Federal, State, and local government representatives attended an UMTA-sponsored paratransit vehicle conference held in May 1981. Two UMTA-sponsored prototypes were displayed along with four other prototype vehicles built by other manufacturers.

RESEARCH COMPLETED

Urban Mass Transportation Administration

Study of ways of making commuter and light rail systems accessible to the elderly and handicapped.—In response to a congressional mandate, the Department submitted to the Congress, in January 1981, a report of one part of a two-part study to determine methods and the desirability of making commuter and light rail transit systems accessible.

Improved communications with the visually impaired, rapid rail systems.—The objective of this project was to identify techniques or equipment of value in making rapid rail transit barrier-free for the visually impaired. The study examined alternative methods of communication with visually impaired persons, including the use of tactile strips, and sound and electronic cueing. This project was completed in September 1981.

RESEARCH ONGOING

Urban Mass Transportation Administration

Analysis of handicapped, by handicap category, to estimate design requirements.—This project analyzes the handicapped by category of handicap, such as the visually impaired or the semiambulatory, to learn more about the specific barriers that restrict their use of transit in order that alternative design changes tailored to authentic needs might be identified.

Demonstration of inclined elevator in Washington Metro.—The Washington Metropolitan Area Transit Authority (WMATA) intends to install an inclined elevator in its Huntington, Va., station. UMTA has awarded a grant for developing the specification for this unconventional technology and for evaluating its acceptability once installed.

Modification to existing escalator.—This research is to determine whether it is feasible to modify existing escalators so they can be used with more ease by persons who have difficulty riding them, including the elderly. The design phase has been completed, resulting in a design for an escalator modification kit.

Search for lower cost elevators.—This research assesses the applicability of certain unconventional elevators to transit and has resulted in identification of the Belgium-designed, screw-actuated elevator as having cost-saving potential when transit systems are newly built or substantially renovated.

Assessment of emergency evacuation procedures and plans, pertinent to the elderly and handicapped.—Objectives are to identify, evaluate, and where necessary, develop methods for insuring safe and timely evacuation of handicapped passengers from transit vehicles. Output will be the identification of "good practices" with regard to evacuation of persons with limited mobility.

New bus equipment introduction program.—Planning is under way for a new bus equipment introduction program to allow transit operators and riders to evacuate various types of buses with different design features, from both foreign and domestic manufacturers. The program will seek, among other things, to improve pedestrian accessibility onto the vehicle.

National design practices manual.—This project is designed to result in a set of documents representing the best practices for cost-effective design, construction, and operation of an urban rail transit system. To be used by engineers and planners, the manual will contain sufficient discussion to permit users to select those practices that fit the situation. Practices to be included will be those that are tested against six criteria, one of which is accommodation of the elderly and handicapped. (Others are safety, esthetics, operating effectiveness, reliability, maintainability, and environmental considerations).

Paratransit vehicles technology program.—This 3-year program, to design and develop prototypes of paratransit vehicles that can be used by both wheelchair users and able-bodied travelers, has resulted in two prototypes that were delivered in the summer of 1981. Space for a wheelchair, wheelchair-fastening systems, and ramps for exiting were included in the designs. Plans are to continue the program with a pilot production build of between 10 and 15 vehicles, to be put into service for evaluation.

Paratransit coordination and integration of social services.—This project is expected to develop and implement a computer-based system to assist agencies in Dade County, Fla., with the idea of improving efficiency and reducing both capital and management costs through use of the computer. Output will be supporting documentation and the computer program.

Wheelchair lift for light rail vehicles.—The project's objective is to develop, test, and evaluate a lift for light rail vehicles. Output will be a specification for a lift.

Gap-problem definition.—This study pertains to the gap between a railcar's floor and the passenger-loading platform. An outgrowth of the congressional mandated rail accessibility study, the project examines what gap dimensions can be traversed by persons in wheelchairs and develops guidelines for designing to meet the gap problem. Output includes operational scenarios of gap filler operation and conceptual designs for gap fillers that would be located on the station platform.

Safety of wheelchair-loading and securement equipment.—Through simulation of crash conditions at 10 and 5 g's, this project aims to learn how the wheelchair behaves when secured by various kinds of fastening devices, in order to determine at what position on the wheelchair it is best to secure the chair to a transit vehicle. Another portion of the project has focused on safety guidelines for wheelchair lifts.

Participation in transportation planning.—A grant was awarded to the American Coalition of Citizens with Disabilities to develop and conduct workshops to train handicapped citizens to participate actively and effectively in the transportation planning process.

Elderly rights to public transportation.—A contract was awarded to Equivest to collect information and prepare a report for elderly people to inform them of their rights under the law regarding the use of public transportation facilities.

A university research grant was awarded to Tuskegee Institute, entitled "A Study of the Transportation Needs of the Elderly and Handicapped in a Small City."

Another university research grant was awarded to the University of the District of Columbia, on "The Non-Utilization of Available Special Transport Services by the Elderly in Urban Areas: A Case Study of Washington, D.C."

DEMONSTRATIONS

Urban Mass Transportation Administration

Rhode Island statewide coordination.—To develop a management plan for State DOT's to coordinate specialized elderly and handicapped service on a statewide basis.

Support for centers for independent living.—Four States have been selected to receive technical assistance in planning transportation services for handicapped persons. This assistance will help local agencies improve their ability to deliver services and will assist UMTA in meeting its goal of improving mobility for handicapped persons through the development and dissemination of "best practices."

Chico, Calif.—To utilize the user side subsidy concept as the catalyst for coordinated social service transportation.

ITEM 12. DEPARTMENT OF THE TREASURY

DECEMBER 14, 1981.

DEAR MR. CHAIRMAN: I am pleased to submit the Treasury's report for "Developments in Aging" on the Department's activities during 1981 which affected the aged. I hope our report will be of use to the Special Committee on Aging and others studying the problems faced by older Americans.

With best wishes.

Sincerely,

DONALD T. REGAN, *Secretary.*

Enclosure.

TREASURY ACTIVITIES IN 1981 AFFECTING THE AGED

The Treasury Department recognizes the importance and special concerns of older Americans, a group that will comprise an increasing proportion of the population in the decades ahead.

ECONOMIC POLICY

The Treasury Department has been involved in the development and implementation of the President's economic recovery program to stimulate economic growth and reduce inflation. The weak and inflationary U.S. economy of recent years has definitely hurt the elderly. Persistent high levels of inflation have reduced the real value of savings and fixed pensions and adversely affected stock and bond markets. High rates of unemployment have reduced opportunities for older workers to find jobs if they so choose. Declining productivity and high inflation have resulted in slow growth and negative real wage growth, thereby exacerbating social security's financing problems. Fewer goods and services means less for everyone. In particular, it hurts the ability of the young to contribute to the old and can lead to intergenerational tensions.

The first condition, therefore, to improving the economic well-being of older Americans is a strong economy. A healthy, growing economy means stable prices, higher standards of living, and greater employment opportunities. Furthermore, stable prices reduce uncertainty concerning the purchasing power that can be expected from asset and other forms of income relied upon by the elderly. Finally, a strong economy provides a higher tax base, which eases the burden on workers who support social security and other types of transfer programs that benefit the elderly.

The Secretary of the Treasury is managing trustee of the social security trust funds. Treasury has been participating in the development of proposals to insure the financial integrity of social security both in the near and longer term.

The agency of the Treasury with whom the greatest number of older Americans have contact is the Internal Revenue Service (IRS). Special activities of the IRS directed at helping persons age 65 and over are detailed in the next section. Activities of other Treasury agencies which affect older Americans are summarized in the last section of the report.

INTERNAL REVENUE SERVICE ACTIVITIES AFFECTING THE AGED

The Internal Revenue Service places considerable emphasis on informing older Americans of their tax rights and responsibilities. IRS also continues to make special effort to inform these individuals who, because of immobility, impaired health, or other factors, may miss out on benefits to which they are entitled unless IRS reaches them directly.

During 1981, IRS expanded assistance to older Americans through the tax counseling for the elderly (TCE) program. Training for TCE volunteers emphasized tax problems of the elderly. Lessons included information on tax credits for the elderly, estimated tax payments, and pension income.

In addition IRS issued a number of informational materials targeted toward older Americans on the following topics:

—Single taxpayers age 65 and over are not required to file a Federal income tax return unless their income for the year was $4,300 or more (as contrasted with $3,300 or more for single taxpayers under age 65). Married taxpayers who could file a joint return are not required to file unless their joint income for the year was $6,400 or more, if one of the spouses was 65 or over, or $7,400 or more if both were 65 or over. This is because all taxpayers age 65 or over get an extra personal exemption of $1,000. (See publication 554 for further information.)

—The special tax credit for the elderly enables persons 65 and over, and also persons under 65 who had pension or annuity income from a public retirement system, to reduce their taxes by as much as $375 if single, or $562.50 if married and filing a joint return. (See publication 524.)

—The entire gain on the sale of a house before July 27, 1978, can be excluded from income if the selling price is $35,000 or less. For selling prices above $35,000, a part of the gain is excludable. For houses sold after July 26, 1978, those age 55 and over are allowed a once-in-a-lifetime exclusion of up to $100,000 of gain on the sale. This exclusion was increased to $125,000 for houses sold after July 20, 1981. (See publication 523.)

—Much of the income received in retirement years is free from Federal income tax. This includes social security payments, railroad retirement benefits, payments from a general welfare fund, and payments for blindness. (See publications 567 and 575.)

—Retirees with taxable pension income can avoid paying estimated tax or receiving a large tax bill at the end of the year by filing form W–4P authorizing the payer of the pension to withhold taxes from the pension payments.

—Tax issues of particular interest to handicapped and disabled people are covered in publication 907.

All publications are available free of charge at IRS offices. They are also used extensively in taxpayer education programs, often in cooperation with organizations interested in the problems of retired persons. In addition IRS personnel provide such services as free tax information by mail, free telephone assistance, and walk-in service at many IRS offices.

IRS uses the print and broadcast media, specialized newsletters, and organizations serving older Americans to communicate tax information of interest to the elderly.

—To publicize the tax counseling for the elderly (TCE) program, in which nonprofit organizations provide free tax information and assistance to individuals age 60 and over, the IRS distributed a 12½ minute film entitled, "A Right Good Thing." The film, which describes tax situations frequently experienced by the elderly and depicts how the older taxpayer can get assistance at a local TCE site, is available free of charge to any interested group or organization.

—To further publicize TCE and other tax benefits for the elderly, two filing-season TV and three rapid shots were produced as well as one set of drop-in ads and one set of cartoons for distribution to magazines, and a taxpayer information materials (TIM) package containing a featurette, a news release, four newsletter items, a question and answer column, live copy radio spots (three in English and two in Spanish), and a 2-minute radio program.

—Two filmed television public service announcements (PSA) were produced and sent to each of the three major networks and approximately 1,000 television stations nationwide. Statistics from Broadcast Advertisers Reports, a firm which tracks the play of commercials and PSA's, indicate that these "Benefits for Older Americans" PSA's were used extensively.

—Four recorded radio PSA's (two in English, one in Spanish, and one with country music background) were sent to the major networks and to about 6,700 local radio stations. Live copy radio material provided to these outlets was also widely used.

—Materials for the print media were provided to newspapers, periodicals, and newsletters nationwide. Print materials were also sent to senior citizen and retirement organizations such as the American Association of Retired Persons, National Council of Senior Citizens, National Retired Teachers Association, and to State offices which service the elderly. A newspaper supplement with an article directed toward older Americans was sent to 9,200 local newspapers.

The following are additional activities in which IRS engaged during calendar easy access to elevators as an aid to elderly and handicapped taxpayers.

—IRS continues its emphasis on securing ground floor space or, alternatively, easy access to elevators as an aid to elderly and handicapped taxptyers.

—During the year articles were published in seven newspapers and/or periodicals warning senior citizens of the danger of their being defrauded by con men impersonating Internal Revenue Service employees. Arrangements were made for an assistant regional inspector to videotape a message on this subject for subsequent screening on three local television stations. In addition IRS inspectors made presentations to senior citizen groups to explain these dangers. Senior citizens were told that if they think they have been contacted by someone impersonating an IRS employee, they should contact local regional inspection offices for assistance. In 1981, inspectors arrested a man who posed as an IRS employee in attempts to defraud two senior citizens.

—During 1981, the Assistant Commissioner (Technical) issued two letters to the White House Conference on Aging. The letters dealt with deductibility under IRC 170 (charitable contributions) of expenses incurred by the delegates and observers attending the White House Conference on Aging. One letter held that delegates who waived reimbursement of expenses were entitled to a charitable deduction for such expenses. The other letter held that their unreimbursed expenses for transportation, meals, and lodging while away from home attending the Conference were deductible as charitable contributions.

—The Assistant Commissioner (Employee Plans and Exempt Organizations) is currently preparing question and answer guidelines on the provisions of the Economic Recovery Tax Act of 1981 that increase benefits under retirement plans. The act has raised the dollar maximum that may be contributed to individual retirement accounts (IRA's), Keogh's, and simplified employee pensions. Furthermore, the act permits many previously ineligible employees to establish IRA's.

REGULATIONS AND RULING ACTIVITIES

—Final regulations were adopted under Internal Revenue Code (IRC) section 37 relating to the income tax credit for the elderly. T.D. 7743 was approved on December 10, 1980. The regulations address questions such as the determination of earned income when a taxpayer receives self-employment income or disability annuity payments and the election available to married taxpayers.

—During 1981, final regulations were published under sections 2039 and 2517 of the Internal Revenue Code relating to the estate and gift tax exclusions of certain retirement benefits.

—Rev. Rul. 81–9, 1981–2 IRB 7, sets out examples illustrating the requirements of section 401(a)(11) of the Code and the regulations thereunder. Section 401(a)(11) requires that qualified retirement plans provide joint and survivor annuities under certain circumstances, extending income protection to elderly spouses of deceased employees.

—Notice 81–1, 1981–2 IRB 32, sets out reporting and disclosure requirements on simplified pension arrangements and provides general information. The impact of these inexpensively administered pension plans should be to make it easier for employers to establish and maintain plans that will provide retirement benefits.

—Rev. Rul. 81–210, 1981–36 IRB 7, explains the effect of increasing or eliminating mandatory retirement age in qualification of an employee retirement plan. The increase or elimination of a company's mandatory retirement age safeguards employment rights of the elderly. However, the effect may also be to lower total retirement benefits by requiring employees to complete more years of service in order to receive fewer years of benefits.

—Rev. Rul. 81-61, 1981–1 IRB 44, holds that the operation of a beauty shop and a barbershop by an exempt senior citizens center is not unrelated trade or business within the meaning of IRC 513. The purpose of the organization, which is exempt under IRC 501(c)(3), is to serve the recreational, intellectual, social, physical, and health needs of senior citizens. Providing the senior citizens with the services of beauticians and barbers in a convenient place contributes to meeting both the psychological and heatlh needs of the elderly.

FORMS ACTIVITIES FOR THE ELDERLY

—The inside front cover of the form 1040 package highlights several changes and important reminders for older taxpayers. Retirees no longer have to fill out schedule E to report pension and annuity income but can report directly on form 1040.

—Taxpayers on social security and others who do not have to report taxable pensions may want to file the "short form" this year as the interest and dividend ceiling has been removed. They may now file form 1040A even if they had interest and dividend income over $400.

—IRS has also made it easier to compute the tax. The four tables from last year have been consolidated into one table covering incomes up to $50,000 with the 5 percent tax reduction effective October 1 built into the table. The IRS will even compute the credit for the elderly for the taxpayer.

—Form W–4P, which is used by retirees to withhold income tax from a pension or annuity, has been revised. The new form has a worksheet on the back which should save retirees a considerable amount of time in determining how much to have withheld.

OTHER TREASURY ACTIVITIES AFFECTING THE AGED

The Treasury Department participated in the 1981 White House Conference on Aging. Treasury coordinated one of the committee sessions entitled. "The Implications of an Aging Population for the Economy," and sponsored a booth at the convention. The booth featured an audiovisual display highlighting the Internal Revenue Service's two volunteer tax assistance programs, VITA (volunteer income tax assistance) and TCE (tax counseling for the elderly).

Other agencies of the Treasury also have an impact on the elderly as part of their specific functions. Developments during 1981 included:

—Treasury continued its expansion of the direct deposit program for Federal recurring payments. This program offers an added measure of convenience and security to many people, including retirees, who depend on regular Government checks by permitting direct deposits into a personal checking or savings account. The service was implemented in 1975 and now includes social security benefit, supplemental security income, civil service retirement, railroad retirement, Veterans Administration compensation and pension payments, and certain military active duty and retirement and Federal salary payments. As of September 1981, over 13.5 million recipients have enrolled in the program, representing over 30.3 percent of total recipients. Since 1977, a nationwide educational campaign has been underway to inform recipients about the advantages of the program. Treasury's goal is to have 55 percent of all eligible recipients enrolled in the program by 1985 and 80 percent by 1990.

—The Office of the Comptroller of the Currency has responsibility for enforcing the Equal Credit Opportunity Act and regulation B. The law and its implementing regulation prohibit a creditor from discriminating against an applicant on a prohibited basis regarding any aspect of a credit transaction. Prohibited basis includes age provided that the applicant has the capacity to enter into a binding contract. Enforcement of the law is carried out during regular examinations of national banks.

—The Treasury also continued to protect elderly recipients of Government payments through the vigilance of the Secret Service. During fiscal year 1981, the Service closed 28,585 social security check forgery cases and 10,450 supplemental security income forgery cases. Most of these checks were issued to retirees. Approximately 52 percent of the checks were cleared, that is, the identity of the forger was discovered.

Finally, the Department of the Treasury makes every attempt to participate in the governmentwide effort to end discrimination against particular groups, including the aged, in employment and in the accessibility of public information and facilities:

—Throughout the Department's facilities, architectural modifications and new buildings include ramps, security bars in restrooms, and other aids to insure that Treasury facilities are usable by all individuals.

—In employment, Treasury offices and bureaus have implemented a part-time employment program (PTEP) as a result of Public Law 93-437 (October 1978). The program gives special attention to groups such as older people. Although the opportunities for employment in general, including part time, are currently uncertain due to budgetary and staffing constraints, the PTEP has helped retirees and the elderly obtain meaningful employment. The employment of the elderly benefits both the individual, by supplementing his or her income, and the agency, by adding productive employees to the regular work force.

ITEM 13. ACTION

December 11, 1981.

Dear Mr. Chairman: I am pleased to respond to your letter of September 10 requesting the submission of ACTION's annual report on programs and services for the elderly to the Special Committee on Aging.

Please do not hesitate to contact me if you have any questions.

Sincerely,

Thomas W. Pauken, *Director*.

Enclosure.

Older American Volunteer Programs (OAVP)

Each of the older American volunteer programs provides opportunities for utilizing the resourcefulness, ingenuity, and skills of persons 60 years of age and over to provide services in their communities. Through their volunteer activities, they strengthen their own and the community's sense of worth by giving their time in the service of others.

There are no educational or experience requirements for enrollment; participation in the foster grandparent and senior companion programs is limited to persons whose income is not more than 125 percent of the poverty line established by the Economic Opportunity Act of 1964, as amended annually. They receive a stipend of $40 for a 20-hour week. The stipend is not considered income for tax purposes nor does it affect eligibility for other Federal or State programs. Retired senior volunteer program volunteers receive no stipend.

All volunteers serve under the sponsorship of local organizations. Categorical grants are awarded by ACTION to private, nonprofit organizations and public agencies to recruit, train, place, and support volunteers. Day-to-day supervision is provided by volunteer stations which are public or private nonprofit agencies and organizations such as hospitals, day care centers, units of local governments, and community social service programs. Under certain circumstances, OAVP volunteers may serve in proprietary health care organizations. ACTION field staff provides tehnical assistance to sponsors and training for project staff. Funding is shared between the sponsor and ACTION.

ACTION is committed to the principle that the satisfaction of each volunteer is a direct result of his or her involvement in activities which will improve the lives of others and enrich their own. OAVP seeks to:

(1) Encourage the recognition of the older person as a solution to problems rather than as a problem.

(2) Promote OAVP projects to develop program activities which include increasing the self-reliance of those served, and mobilization of local resources to meet community needs.

(3) Coordinate OAVP program activities with other ACTION programs, and with programs of other governmental and nongovernmental agencies.

(4) Encourage volunteer assignments in RSVP and FGP which increases cross-generational contacts.

(5) Encourage increased State and local funding of OAVP and OAVP-type projects.

The OAVP program concept has been greatly expanded by the use of State and local monies to crease non-ACTION OAVP-type projects or to supplement existing ACTION projects. More than 30 States and local governments are providing approximately $15 million for this purpose. These funds are in addition to the required local matching funds provided by all project sponsors. Since most State and local projects wish to be identified with one of the respective OAVP program titles, they have entered into written memoranda of understanding with ACTION. These memoranda allow the local projects to use the generic Federal program name and make the volunteers serving in these projects eligible under the income disregard provision of ACTION legislation with respect to foster grandparent and senior companion programs. Project staff participate in ACTION training activities, receive program assistance materials, and utilize the technical expertise of ACTION staff.

Volunteer total and funding for fiscal year 1981 was:

	Millions
RSVP (300,000 volunteers)	$27.7
FGP (18,030 volunteers)	48.4
SCP (5,280 volunteers)	12.8
Total	88.9

FOSTER GRANDPARENT PROGRAM (FGP)

The foster grandparent program (FGP) was originally developed as a cooperative effort between the Office of Economic Opportunity and the Department of Health, Education, and Welfare. It was given a legislative base in 1969 and transferred to the Administration on Aging in HEW. In July 1971, the program was transferred to ACTION.

The FGP enables low-income persons aged 60 or over to remain active in their community through person-to-person service to children with special or exceptional needs in health education, welfare, and related settings. The foster grandparents derive a renewed sense of dignity and self-worth from their special service roles. In addition to a stipend of $2 per hour for a 20-hour week, they receive additional tangible benefits in the form of transportation to and from their volunteer station, a noon meal on the days (usually 5 days per week) they serve, accident and liability insurance, and an annual physical examination.

Children are assigned foster grandparents on the basis of their potential for improvement in personal or social adjustment, skill development and for deinstitutionalization. In the latter case, foster grandparents will follow deinstitutionalized children needing continuing attention to their own homes when possible and approved. Initial assignments of foster grandparents are also made in cases where they can have the greatest impact in the delay or prevention of institutionalization of children living in a home environment.

Foster grandparents give attention and affection to the chidlren to whom they are assigned. Ideally, the volunteers spend 2 hours with each of two children on a daily basis. Some group sittings are not appropriate for a strict one-to-one assignment basis. In these cases, foster grandparents may serve several children as long as the setting is conducive to the establishment of person-to-person relationships among the volunteers and the children they serve. The program provides social, psychological, and educational benefits to children with developmental disabilities and related special needs. The foster grandparents simultaneously benefit from alleviation of some of the consequences of poverty and loneliness. Their psychological outlook and physical health are improved. The mutually benefiting relationship also has a notably positive effect on the children's development and the outlook of their families. The program provides a degree of protection of human rights of both "grandparent" and "grandchild," ensuring that each group is dealt with fairly and humanely.

Foster grandparents are provided orientation prior to assignment to individual children. Subsequently they are provided monthly in-service training. They function as stipended volunteers and are not in the regular work force. Their activities are limited to those which would not supplant the hiring of or result in the displacement of employed workers, or impair existing contracts for service. Foster grandparents may not provide physical therapy, babysitting service, housecleaning service, or other services normally performed by volunteer station staff to the children they serve. Foster grandparents are expected to accept supervision of volunteer station and project staff. Appropriate volunteer grievance and appeal procedures are the responsibility of the individual project sponsors.

Project staff are employees of the project sponsor; they are not employees of the Federal Government. ACTION requires concurrence in the selection of project directors.

The project director, on behalf of the sponsor, recruits, trains, and exercises general supervision over the volunteers. This person also develops memoranda of understanding with volunteer stations where volunteers are to be placed. He/she also ensures that foster grandparents are assigned to children with demonstrated special or exceptional needs.

Project sponsors, in accepting ACTION grants to operate foster grandparent projects, agree to abide by agency regulations and policies. ACTION, in turn, provides training and technical assistance to sponsors and project staff, and promotes cooperation and coordination with other Federal, State, and local entities concerned with the needs of low-income elderly and children with special or exceptional needs, including transportation needs.

The foster grandparent program addresses the most pressing basic human needs both in seeking the poorest of the poor to serve as foster grandparents, and in the selection of individual children the volunteers serve.

During the entirety of fiscal year 1981, the program operated under authority of a continuing resolution at a level of $48.4 million. At year's end there were 18,030 funded foster grandparents serving approximately 54,090 children. There are 233 (federally funded) projects with at least one project in each State, Puerto Rico, the Virgin Islands, and the District of Columbia. Additionally, more than 30 States have now appropriated varying sums to expand foster grandparent opportunities and services. Michigan presently leads the way in this regard with nonfederally funded projects, providing approximately 360 additional low-income elderly residents the opportunity to serve in and benefit from the program.

RETIRED SENIOR VOLUNTEER PROGRAM (RSVP)

The retired senior volunteer program was established to provide a variety of opportunities for persons, aged 60 or over, to participate more fully in the life of their community through significant volunteer service. Through RSVP, over 300,000 older Americans are making significant contributions toward solving some of the pressing problems of their communities. In turn, the program enables the elderly to find the dignity and usefulness they seek.

RSVP was originally authorized in 1969 and funded in 1971. In July 1971, it was transferred to ACTION. In 1981, RSVP celebrated its tenth anniversary. Over the last 10 years, several thousand communities all over the country have benefited from the efforts of the retired senior volunteers.

RSVP is inherently a local community program. Each RSVP project is locally planned, operated, controlled, and supported. The non-Federal support of the budget is not required to be more than 10 percent during the first year. Project sponsors are expected to increase local support of the project budget by 10 percent each of the second and third years, assuming at least 30 percent financial responsibility each year thereafter.

A person, 60 years of age or over, is eligible to enroll in the program. There are no income, education, or experience requirements to become an RSVP volunteer. Orientation, in-service instruction and recognition are provided for the volunteers. Volunteers serve without compensation, but transportation assistance is provided between their homes and volunteer assignments when needed. Accident, personal liability, and, when appropriate, excess auto liability insurance are provided.

The retired senior volunteer program promotes older citizens as a resource capable of improving community life. They serve in hospitals, schools, courts, crisis centers, and other similar agencies, assisting clients of all ages. They are involved in projects dealing with health care delivery, energy conservation, operation of food co-ops, and fixed income counseling. Numerous examples illustrate the value of the contributions of RSVP volunteers to their communities.

In Eustin, Fla., volunteers work on a one-to-one basis with youthful offenders, providing educational and occupational counseling. Based on the number of youths from the program who have gone on to get high school diplomas and jobs, the program appears to be working remarkably well.

In Morris Plains, N.J., 37 volunteers participate in the RSVP/FICC component serving through outreach offices and county nutrition sites. They provide information and hold symposiums on legal benefits, coupon shopping, Medicare and income tax.

In Chillicothe, Mo., about 40 volunteers serve in many different roles in the school systems. They record books for students with impaired vision and learning disabilities and serve as teachers' aides in the elementary schools.

Over the years, several experimental efforts involving existing projects have been implemented to ensure the development of more innovative service opportunities for volunteers now serving in the program.

In 1979, 10 RSVP projects were given additional funds and training to establish components in fixed income consumer counseling (FICC) that would recruit and train volunteers to assist persons on fixed incomes in areas such as: health and nutrition, crime and victimization, banking, financing, rebate programs, legal aid, and other services.

With funding support and technical assistance provided by a cooperative private agency, 22 RSVP projects started work in 1980 to establish test components with volunteers who will provide community support services to hardcore unemployable youths between the ages 16 and 21.

In late 1981, RSVP is embarking on a cooperative demonstration effort with the senior companion program (SCP) in the provision of services to persons in need of long-term care to remain in their own homes, and two RSVP projects will participate. These demonstration efforts will examine various policy questions and test specific variations in program models and volunteer service activities.

A total of $122,000 has been allocated to all 10 regional offices from fiscal year 1981 funds to establish or expand programming initiatives in the following areas: (1) Service to youth; (2) inflation fighting; (3) long-term care; and (4) crime prevention. These funds are expected to produce a minimum of 1,220 new volunteers. Since 1971, the retired senior volunteer programs has experienced considerable growth. At the beginning of 1972, with a new budget of $15 million, there were 34 RSVP projects and 1,816 senior volunteers. By the end of fiscal year 1981, with a budget of $27.7 million, there were 729 federally funded projects and over 300,000 senior volunteers participating nationwide. There are RSVP projects currently operating in all 50 States, the District of Columbia, Puerto Rico, Guam, and the Virgin Islands. Seventeen States have appropriated a total of over $2 million in support of program activities.

Older Americans are a national resource of tremendous worth. And as the need for volunteer services becomes even more pressing, the experience and ability of the more than 300,000 RSVP volunteers will become increasingly valuable.

SENIOR COMPANION PROGRAM (SCP)

The senior companion program offers volunteer opportunities to adults, age 60 and older, who have annual incomes which fall below the poverty guideline. The senior companions (volunteers) provide personal assistance and companionship to primarily older adults in an effort to support them in achieving their highest level of independent living.

The senior companion program has grown from 18 pilot projects and 1,000 senior companions in fiscal 1974 to 79 projects and approximately 5,280 senior companions as of October 1, 1981. The operating budget in fiscal year 1981 was $12,783,000.

The senior companion program provides a visible demonstration that older persons can perform a critical role in contributing to the solution of problems that effect them. SCP fosters independence and enhances the self-esteem of the senior companions by engaging them in activities which improve the lives of individuals and communities.

SCP assists in the long-term care needs of moderately and generally impaired adults, focusing on older adults whose physical, mental, and emotional impairments put them at risk of inappropriate or unnecessary institutionalization. Senior companions are placed at or through volunteer stations which are direct health care providers, social service agencies, and Federal and State long-term care networks.

In Scranton, Pa., 80 senior companions provide services to more than 400 frail elderly. The primary goals of this project are to facilitate discharge from acute care hospitals and prevent unnecessary readmissions. Senior companions meet patients prior to discharge and continue to serve them during the crucial transition period to their own homes. The hospital administration has observed that many patients have been discharged who otherwise would have remained in the hospital because of social problems.

Washington, D.C. received a grant for a senior companion project in October of 1980. In one short year, this project has recruited their full complement of senior companions, served more than 350 frail elderly, and established 13 volunteer stations around the community. One of their volunteer stations is a general hospital where senior companions provide services in a ward where adults are treated for substance abuse problems. The senior companions concentrate on the older patients, who they serve both in the hospital and at home, once the patient is discharged.

Another senior companion volunteer station provides service and treatment to the terminally ill. The role of the volunteer is to provide companionship, compassion, and support to the dying patient.

Approximately 80 percent of the senior cmopanions are assigned to assist older persons to remain in their own places of residence.

The senior companions also assist clients in patient-release programs in acute care hospitals, mental health, and other long-term care facilities to make the transition and adjustment to living in less restrictive settings.

In all placements the senior companions serve as advocates by linking clients to appropriate services and assuring that they receive benefits to which they are entitled.

Senior companions receive a small stipend for their service. They are also provided or reimbursed for transportation and meals for days of service, orientation, or training. Volunteers are covered by accident and liabiilty insurance and receive annual physical examinations. Senior companions are also provided an orientation and regularly scheduled in-service instruction.

During fiscal year 1981, 15 new senior companion projects were initiated. These projects were designed to include: (1) The integration of senior companions into a plan of care developed by community organizations with the capacity to coordinate the health and social needs of clients served; (2) enrichment of volunteer training; (3) increasing the role of the senior companion clients and other low-income persons in the advisory council; (4) strengthening of volunteer station roles and responsibilities; and (5) expansion of senior companion program services to special at-risk populations, the mentally impaired, the aging, those with substance abuse problems, and patients from acute care hospitals.

ITEM 14. COMMISSION ON CIVIL RIGHTS

FEBRUARY 16, 1982.

DEAR MR. CHAIRMAN: The U.S. Commission on Civil Rights is pleased to respond to your request for a statement concerning our fiscal year 1981 activities affecting the interests of older persons.

The U.S. Commission on Civil Rights is a temporary, bipartisan agency within the executive branch of the Federal Government, established by the Congress in 1957, and directed among other things, to study and collect information about legal developments relating to discrimination because of race, color, religion, sex, age, handicap, or national origin and to appraise Federal laws and policies with respect to discrimination or the denial of equal protection of the laws, and submit reports, findings, and recommendations to the President and the Congress.

Before October 1978, the Commission's jurisdiction over "age" and "age discrimination" matters was limited to a special short-term mandate of the Age Discrimination Act of 1975 (Public Law 94–135) that the Commission study and report on the nature, scope, and extent of age discrimination in federally assisted programs. The Civil Rights Commission Act of 1978 (Public Law 95-444), however, expanded the Commission's general authority to include matters related to age discrimination.

In addition, the 1978 amendments to the Older Americans Act (Public Law 95–478) directed the Commission to undertake a study of race and ethnic discrimination in federally assisted programs and activities for older persons, examining in particular employment, the award of contracts, and the delivery of services. Although no funds have been appropriated by Congress to finance the costs of the study, the Commission allocated a portion of its existing budget to conform essentially to the intent of Congress. This study is being conducted in two phases. The first phase was completed in the latter part of fiscal year 1981. In this phase the Commission investigated minority participation in federally assisted programs and activities in six communities across the country: Cleveland, Ohio; Bridgeport, Conn.; Tucson, Ariz.; Tulsa, Okla.; San Francisco, Calif., and Honolulu, Hawaii. Investigations focused on programs funded by title III of the Older Americans Act which provides funds for social services and congregate and home-delivered meals. Although this portion of the study has not been released, an executive summary outlining the Commission's investigations was distributed in November 1981, at the White House Conference on Aging. A copy is enclosed.

The second portion of the study which was begun in fiscal year 1981, will include data analysis for questionnaires completed by the State units on aging and the area agencies on aging and the results obtained from interviews with officials at the Federal level. The Commission anticipates issuing the entire study in fiscal year 1982.

The regulations of the Age Discrimination Act provide for the Department of Health and Human Services to undertake a major evaluation of the implementation of the Older Americans Act. Pursuant to this, the Department has established an interagency advisory committee on which Commission staff regularly participate in the evaluation of age discrimination complaint mediation by the Federal Mediation and Conciliation Service.

The 51-State Advisory Committee to the Commission monitors activities affecting the interests of older persons. The Commission continues to respond to requests for information on aging. In research projects and investigations, the Commission takes steps to include, where feasible, concerns related to the Commission's age jurisdiction.

If we can be of any further assistance, please let me know.

Sincerely,

JOHN HOPE III,
Acting Staff Director.

Enclosure.

PROVIDING SERVICES TO THE MINORITY ELDERLY—NEW PROGRAMS, OLD PROBLEMS

EXECUTIVE SUMMARY

Title III of the 1978 amendments to the Older Americans Act [1] mandated that the U.S. Commission on Civil Rights: "(1) Undertake a comprehensive study of discrimination based on race or ethnic background in any federally assisted programs and activities which affect older individuals; and (2) identify with particularity any such federally assisted program or activity in which evidence is found of individuals or organizations who are otherwise qualified being, on the basis of race or ethnic background, excluded from participation in, denied the benefits of, refused employment or contracts with, or subject to discrimination under, such program or activity." [2]

The manadate for the Commission's study of racial and ethnic discrimination in federally assisted programs for older persons, in part, emanated from a Commission finding in its earlier age discrimination study which indicated that older members of minority groups were often victims of age, as well as racial or ethnic discrimination.[3] The mandate also arose from congressional testimony during consideration of the 1978 amendments to the Older Americans Act which suggested that minority older persons were not fully participating in federally assisted programs. Testimony on the problems of older minorities documented their need for Federal service programs, although not necessarily their receipt of their fair share of service benefits.[4] Census data also documented that proportionally a larger number of older minorities are in poverty than older whites. Data gathered revealed that the likelihood of older blacks being impoverished is three times greater than that of older whites. Among older Hispanics the poverty rate was nearly double that of older whites. Similar statistics are not available for Asian and Pacific Island Americans nor for American Indians.[5]

---

[1] Responding to the call for a national program of services to improve the condition of life for all older persons, in 1965, Congress passed the Older Americans Act. The Older Americans Act represented one of the first major attempts by the Federal Government to address the social needs of all older persons on a national level. In October 1978, Congress enacted extensive revisions to the Older Americans Act. Titles III, V, and VII were consolidated under a new title III. Under the revised title III grants are made to States to provide nutrition services, multipurpose senior centers, and a comprehensive array of social services to older persons. (Older Americans Act, Public Law No. 89–73, 79 Stat. 218, as amended. 42 U.S.C. §§ 3001–3057g (1976 and supp. III 1979)).

[2] 42 U.S.C. § 1975c note (supp. III 1979).

[3] U.S. Commission on Civil Rights, "The Age Discrimination Study" (December 1977), page 24. The 1975 Age Discrimination Act, part of the 1975 amendments to the Older Americans Act, made unlawful unreasonable discrimination on the basis of age in the delivery of services supported in whole or in part by the Federal Government. Public Law 94–135, 89 Stat., 713, 728 (codified at 42 U.S.C. §§ 6101–03 (1976)).

[4] "Proposed Extension of the Older Americans Act of 1965 and Oversight on the Age Discrimination Act of 1975," hearings before the Subcommittee on Select Education of the House Committee on Education and Labor, 95th Cong., 2d sess. 248–59.

In responding to the mandate of Congress, the Commission designed a two-phase study: Case study analyses of selected cities and mail surveys of all State units on aging and area agencies on aging[6] and interviews with Administration on Aging officials. Through in-depth examination of the operations of title III Older Americans Act programs funded by the Administration on Aging[7] the Commission sought to assess: (1) Whether and in what capacities minorities are employed under the programs for older persons; (2) whether and to what extent minority firms and organizations are awarded contracts and grants under the programs; and (3) whether and to what extent older minorities receive the services provided by these programs.

The study is being published in two parts. Part I, to which this executive summary relates, includes the six-case analyses, an introduction, a chapter which discusses the Older American Act and a general summary with glossary. The first section of each city's case analysis chapter provides a demographic profile and an historical discussion of the area agency on aging and its administrative structure. The second section discusses minority representation on the area agencies on aging staff; the recruitment, hiring, and promotion of minorities and affirmative action activities. The third section describes minority representation among contractors and subcontractors and efforts to recruit more minority contractors.[8] This section also discusses the employment of minorities by contractors and subcontractors and contract compliance activity by the area agencies on aging. The fourth section examines minority participation in five major service categories (access, in-home, legal, other social services, and nutrition services)[9] and discusses program characteristics that appear to facilitate or impede minority participation in area agencies on aging programs. That section concludes with a discussion of the area agencies on aging service planning and program evaluation procedures and their inclusion of minority concerns. The fifth section summarizes the results of the Commission's investigation[10] (A limited supply of copies of part I are available from the U.S. Commission on Civil Rights upon request.[11]

The six communities were selected to include geographically diverse sites having substantial representation of American Indians, Asian and Pacific Island Americans, blacks, and Hispanics.[12] Since the minority older population is largely an urban population, greater emphasis was placed on urban site selection. Both large- and medium-sized cities were selected. Special attention was given to the representation of each of the racial and ethnic groups noted. The six cities chosen were Bridgeport, Conn.; Cleveland, Ohio; Honolulu, Hawaii; San Francisco, Calif.; Tucson, Ariz.; and Tulsa, Okla.

---

[5] U.S. Department of Commerce, Bureau of the Census, "Money, Income, and Poverty: Status of Families and Persons in the United States: 1978," series P-60, No. 120, page 32.
and subcontracts and subgrants, respectively.

[6] A State unit on aging is the single State agency designated to develop and administer a State's program for older persons. It serves as the focal point on aging in the State. An area agency on aging is an agency designated by the State unit on aging to develop and administer the plan for a comprehensive and coordinated system of services for older persons in a designated area of the State.

[7] The Administration on Aging serves as the focal point of management for Federal program activity under the Older Americans Act. In fiscal year 1980, the Administration on Aging had 10 regional offices and 57 State units on aging (including the District of Columbia, Puerto Rico, Guam, Samoa, the Pacific Island Trust Territories, and the Northern Mariana Islands); there were 654 area agencies on aging at the local level. Area agencies on aging, in turn, generally make grants to private, nonprofit organizations for actual service delivery.

[9] Access services provide older persons with better entree to other services. They include, for example, transportation, outreach and information and referral services. In-home services provide in the home care to help keep older persons in independent living situations. In-home services may include homemaking, visiting, and telephone reassurance, and chore maintenance services. Legal services are provided to help increase the availability of legal consultation and representation to older persons. Nutrition services provide meals to older persons in either a congregate or in-home setting.

[10] Part II will include data analysis from the State units on aging and the area agencies on aging questionnaires and the results obtained from interviews with officials at the Federal level. The survey results will provide an aggregate assessment of minority participation in State units on aging and area agencies on aging programs and thus will supplement the case analyses findings. The findings and recommendations for the entire study (parts I and II) will be published at the end of part II of the report, so that they may reflect the results of the case analyses and the national data analysis.

[11] Copies may be obtained by writing the U.S. Commission on Civil Rights, Publications Warehouse, 621 North Payne Street, Alexandria, Va. 22314, or by telephoning (703) 557-1794.

[12] The design for the study also called for coverage of Euro-ethnic Americans. Once field work began, the Commission discovered that it was often impossible to obtain information on the employment or award of contracts to Euro-ethnic Americans. Almost without exception, these data were nonexistent. Also, statistics on participation by Euro-ethnic older persons were not separated from those of persons of other European descent. In most instances neither the area agency on aging nor its service provider had data on Euro-ethnic participation and thus, efforts to include this group in the study had to be abandoned.

Local area agency on aging administrators, social service providers (area agency on aging funded and nonarea agency on aging funded), representatives of community organizations, and area agencies on aging advisory council members in each community were interviewed and questioned on their perceptions of efforts to provide services to the minority community. During the field investigation, the Commission staff sought: (1) To identify program characteristics that affect minority participation, and (2) to obtain information on (a) staffing patterns of the area agencies on aging and its contractors; (b) the area agencies on aging's identification and selection of contractors; (c) the area agencies on aging's affirmative action activities, and their methods of outreach to minorities; (d) the extent of minority participation in program management, administration, and evaluation; and (e) types of area agencies on aging monitoring and compliance activities. The Commission staff discovered similar results in each of the cities visited. Among the findings common to all six communities investigated were the virtual absence of minorities in decisionmaking positions among the area agency on aging staff, low representation of minority firms and organizations among area agency on aging contractors, and underrepresentation of older minorities as participants in area agencies on aging service programs.

Results of the Commission's six city investigations indicated that in most communities some minorities were included among Older Americans Act program participants as area agency on aging employees. Rarely, however, was minority involvement reflective of their representation in the population. Blacks, while employed by most area agencies on aging, were generally underrepresented in policy and supervisory positions on the area agencies on aging's staff. In most cities, where employed, Hispanics were found largely in clerical and paraprofessional jobs and quite often worked only part time. American Indians and Asian and Pacific Island Americans generally were absent from the area agency on aging staff. (The exception was Honolulu where Asian and Pacific Island Americans constituted the majority of persons on staff.) Bilingual staff were normally absent from area agencies on aging employment rosters. In none of the cities was there a requirement for any bilingualism among program staff (and particularly information and referral staff), even where population data would project a need. Almost none of the area agencies on aging had a formal recruitment procedure for increasing minority representation among staff, despite certain minority groups' underrepresentation among program staff.

Almost all of the area agencies on aging had affirmative action plans, although they generally were a part of a larger municipal affirmative action plan. In most cases, despite the fact that previous affirmative action plans contained specific goals for hiring minority staff, these goals had not been reached. Furthermore, in almost no instance where goals were unmet by area agencies on aging had substantive corrective actions been taken by the State units on aging or the Administration on Aging.

In almost none of the cities was minority firms receiving a representative number of contracts or amount of title III contract funds from the area agencies on aging, in spite of the fact that such firms often were in a position to render unique services and had displayed the ability to provide effectively services for achieving title III objectives.

In Cleveland, Bridgeport, Tulsa, and San Francisco, there were black organizations receiving relatively small contract amounts. In Bridgeport and San Francisco a few Hispanic firms were contractors and received small grants. In Tulsa and San Francisco there were American Indian firms that contracted with the area agency on aging. In San Francisco there were Asian and Pacific Island Americans firms that contracted for service delivery. In virtually all cases minority organizations were not receiving a fair share of the moneys available. Nevertheless, there were few formal mechanisms in place to provide technical assistance to potential minority contractors that would help to increase their representation among contractors in the cities examined. In most cities visited, representatives of minority organizations stated that the failure to provide standardized technical assistance by the area agencies on aging was one reason for the lack of minority contractors. They also voiced concern that the lack of technical assistance actually was a reflection of the area agencies on aging's unwillingness to try actively to serve or increase minority participation in service programs. Additionally, where subcontracting was done, contractors were not specifically encouraged by the area agencies on aging to subcontract with minority firms.

Generally, contractors were not required to have affirmative action plans. Further, contractors' employment patterns and practices were normally not actively monitored by the area agencies on aging. Minority employment by title III contractors generally was not reflective of minority representation in the total population. In general, with the exception of minority firms, contractors which employed minorities did not employ them in supervisory or decisionmaking positions.

The 1978 amendments to the Older American Act, unlike earlier legislation, make no specific reference to inclusion of minorities as a priority. Instead, previous references to service delivery priority for minorities have been replaced by references to priority being given to those in "greatest social and economic need." The act itself provides that State and area agencies, in their respective plans, give preference to older persons with the greatest economic or social need. The Administration on Aging, in its regulations for implementing the act, allows State and local officials to use the U.S. Bureau of the Census measure of the poverty level as a proxy for the definition of "greatest economic or social need." [13]

In all of the cities visited, minority older persons were in poverty at a much higher rate than nonminority older persons. Because of their relative poverty, the extent to which minority older persons participate indicates the degree to which area agencies service programs have succeeded in giving priority to persons in greatest economic and social need, without its resulting in discrimination against minorities.

In almost every city, minority older persons were being underserved. Black elderly generally were among program participants in almost all of the cities, but usually in very small numbers. Older Hispanics also generally were participating, although in inconsequential numbers. American Indian elderly were virtually absent from service programs in all cities. The only cities with substantial numbers of older Asian Amercan participants were Honolulu and San Francisco. While older minorities participated to some extent in all title III programs, there were some services (e.g., in-home services and legal services) in which they were consistently absent across all six cities.

Also during its investigations, the Commission staff was told by representatives of minority elderly that older minorities in the six geographic locations often felt that Older Americans Act programs were unresponsive to their needs and priorities. Generally, nutrition programs did not provide culturally appropriate meals or meals reflective of diverse cultures represented in the city. This contributed to the relatively low rate of participation by minority older persons, according to many representatives of minority organizations who serve the elderly. In most cities there was limited written material available about area agencies on aging programs in English, and even less in other languages. Very little other publicity (e.g., media spots, displays) was available about the program, and again, especially in languages other than English. In most of the six cities, information and referral services generally did not have any bilingual employees.

Despite low participation by minority elderly in most service programs, area agencies on aging were not actively involved in outreach activities designed specifically to include more minority elderly. The Commission found that an area agency's failure to do active outreach in minority communities sometimes resulted in the servicing of those in greatest economic and social need to the exclusion of older minorities who, in most instances, also fell into the greatest social and economic need category. The existence of limited outreach programs, together with programs unresponsive to minority elderly needs, has resulted in low minority participation in almost all cities.

The Commission found that the area agencies on aging generally were not monitoring and evaluating their programs regarding participation in services by older minorities. Minorities were not usually actively involved in the area agencies on aging planning process. In some of the six cities, members of certain minority groups were not represented on the advisory council. The Commission noted that an area agency's failure to include minority older persons in the planning and implementation of services may have helped to determine the extent to which all minority older persons, and especially those in greatest economic and social need, were restricted or excluded from full participation in Older Americans Act service programs.

---

[13] 42 U.S.C. § 3024(a)(1) (supp. III 1979). There are no eligibility criteria for most programs funded under title III. These programs are entitlement programs.

Another major finding common to almost all of the six communities was the absence of efficient data collection on minority participation in service programs. In most of the case analysis sites, area agencies on aging were not collecting information for planning purposes by race or ethnicity, making the determination of minority needs, potential service use or factors that affect minority participation difficult. Further, the area agencies on aging were not being monitored closely by the State units on aging or the Administration on Aging regarding civil rights compliance.

While findings regarding minority participation in the area agencies on aging programs were very similar for all cities visited, the Commission also discovered that each city had its own special characteristics. Below are short summaries that highlight the findings in each of the six cities visited. Each city summary reports Commission findings regarding minority employment and receipt of grants, contracts, and services. The data collected in the six cities point to policies and practices followed by area agencies on aging and their contractors that adversely affect minority participation in title III funded programs. The data from the national survey to be published as part II of the report should provide a solid basis for developing national findings and recommendations.

CITY SUMMARIES

Cleveland, Ohio

Minorities in Cleveland were generally underrepresented in all phases of title III programs for older Americans administered by the Western Reserve Area Agency on Aging. An examination of the membership of the Western Reserve Area Agency on Aging's advisory council revealed that of the 43 members, 9 were black. No American Indians, Asian Americans, or Hispanics had been selected to serve on the area agency's advisory council.

Blacks were the only minority persons employed by the Western Reserve Area Agency on Aging. American Indians, Asian Americans, and Hispanics did not hold any Western Reserve Area Agency on Aging jobs. Black representation on Western Reserve Area Agency on Aging staff was a direct result of a deliberate effort by the Western Reserve Area Agency on Aging to increase minority representation. Despite inclusion of Hispanics as a target group in its affirmative action plan, the Western Reserve Area Agency on Aging had thus far failed to hire any Hispanic employees.

Black organizations were the only minority agencies receiving funds from the Western Reserve Area Agency on Aging. Three Black organizations received 10 percent of the title III–B (social services) funds awarded in Cleveland and four Black organizations received 11 percent of the title III–C (nutrition) funds awarded. Minority agencies cited lack of outreach and technical assistance as major reasons for minimal minority representation among contractors. According to many minority representatives, without more intensive efforts by the Western Reserve Area Agency on Aging in outreach and technical assistance, minority organizations were likely to continue to lag far behind other organizations in obtaining contracts. Another factor which appeared to limit the number of minority contractors was a requirement that potential contractors have their own funds and be able to guarantee a continuing source of funds before a contract was approved. According to community representatives, this criterion was often difficult for minority organizations to meet.

Although most contractors employed relatively few minorities on their staffs, Western Reserve Area Agency on Aging had not required contractors to increase minority employment. Generally, contractors without minority employees had not been censured. For example, the Western Reserve Area Agency on Aging was increasing the funding of the Visiting Nurses Association although this contractor had no minority nurses in their title III program.

In almost every title III service, Cleveland's minority elderly were being underserved in relation to their representation in the eligible population in Cleveland and even more so in relation to their relative social and economic needs. Black senior citizens participated in all Western Reserve Area Agency on Aging-funded social services, but they were underrepresented in 11 of the 17 services. Asian American elderly participated in 8 of the 17 services but constituted less than 1 percent in 7 of the 8. American Indian elderly participated in 4 services at less than 1 percent. Hispanics participated in 13 services; always in very low percentages.

Minority older persons also were not being fully served by the Western Reserve Area Agency on Aging's nutrition program. Asian American and American Indian older persons were participating in nutrition programs at a rate of less than 1 percent.

Minorities were not participating fully in multipurpose and focal points centers in Cleveland that provided a wider variety of social service programs. The Western Reserve Area Agency on Aging began designating focal points in 1979. Three were located outside Cleveland and three focal points were located in Cleveland. Only one of the three centers in Cleveland served a predominantly minority clientele. The one center that served the Hispanic aged lacked the full resources of a focal center. Another focal point center, Deaconess Krafft Complex (Brighton) was located near a Hispanic community. Hispanic elderly were less likely to use its services because established transportation boundary lines did not include their area. The factors that appeared to impact upon minority participation in Cleveland included whether the service provider was a minority organization, the extent of minority employment by service providers and the service location.

Bridgeport, Conn.

Bridgeport is the largest city in Connecticut and contains a sizable population of minorities (21 percent black, and 18.7 percent Hispanic). The city also has the highest proportion of older minorities (47 percent of all black, and 42 percent of all Hispanic elderly) in the southwestern Connecticut planning and service area administered by the Southwestern Connecticut Agency on Aging.

Black representation on the Southwestern Connecticut Agency on Aging's advisory council and board of directors was reflective of their representation in the local population (23.3 and 20 percent respectively). Hispanics were also represented on both of these groups (3.3 and 5 percent respectively), while American Indians and Asian Americans were not represented. A recent increase in hiring and promotion of minorities had resulted in close to 50 percent minority representation on the Southwestern Connecticut Agency on Aging staff. However, no minorities held decisionmaking positions.

Two of the nine title III–B contractors servicing Bridgeport were minority organizations. The Federation of Neighborhood Councils and the Spanish American Development Agency received 37.5 percent of Title III–B funds awarded in Bridgeport during 1980. More than half of Southwestern Connecticut Agency on Aging's nonminority contractors serving Bridgeport did not have minority employees. Out of a total of eight, five had exclusively white staffs. Blacks represented 13.3 percent and Hispanics 9.5 percent of the persons employed in Southwestern Connecticut Agency on Aging funded programs in Bridgeport, and held management level positions only in minority operated programs. During 1980 employment of minorities by nonminority contractors remained constant.

In 1980, minority organizations and Southwestern Connecticut Agency on Aging jointly sponsored a workshop to inform potential minority contractors about Southwestern Connecticut Agency on Aging and its resources. It was the first such effort to attract more minority contractors, and one minority firm was awarded a transportation contract.

Minorities were served by all 13 contractors and subcontractors operating in Bridgeport. Programs set up or operated by minorities tended to have higher minority participation rates. Service rates to minorities were much lower among the nonminority contractors. The single exception was the interfaith friendly visiting program. Service delivery to minorities was increased from approximately 16 to 21.2 percent in 1980.

Compliance with Federal nondiscrimination requirements in service delivery was accomplished mainly through onsite reviews conducted twice yearly. Ongoing monitoring for compliance took place with the review of monthly and quarterly reports submitted by contractors.

Tucson, Ariz.

The city of Tucson, Ariz., is diverse in its racial and ethnic composition. The largest minority group in Tucson is Hispanic, representing 24.9 percent of the city's total population. Tucson also had a sizable minority elderly population who, relative to white Anglo elderly, disproportionately were in poverty. The area agency with jurisdiction over Tucson is the Pima Council on Aging (PCOA). There were black, Hispanic, and American Indian representatives on the Pima Council on Aging's advisory council. There were no Asian American representatives on the council.

Minorities were not represented on its title III funded staff. The Pima Council on Aging is required to have an affirmative action plan and submit the plan to the State unit on aging. According to Pima Council on Aging representatives, the council had not been able to implement the plan since there was so little staff turnover at the agency.

In 1980, PCOA funded four contractors under title III to provide legal aid, home health aide and chore maintenance, housing renovation, and nutrition services. None of the contractors was minority. The Pima Council on Aging anticipated no new contractors, since all additional funds Pima Council on Aging received would go into maintaining or expanding the existing contractors.

For the most part, minorities were not employed in decisionmaking positions within title III funded programs. One exception to this was the city of Tucson's housing renovation program whose director was Hispanic. Although all contractors were required to have affirmative action plans, Pima Council on Aging staff said that the agency did not have enough staff to monitor contractors' efforts.

Three title III–B programs served Tucson's elderly: in-home services, legal aid services, and housing renovation services. Only three American Indians and no Asian Americans were participating in the in-home health aide and chore maintenance services. The legal aid program was neither serving American Indians nor Asian Americans. Minority elderly received a greater share of services under the housing renovation program, but American Indians and Asian Americans were not served by it. Senior Now Generation provided all of the Title III–C nutrition services in Tucson. With the exception of kosher food, no culturally appropriate meals were provided.

Tulsa, Okla.

Tulsa, with a population of 360,919, is the second largest city in Oklahoma. Minorities accounted for 16 percent of this population, nearly 4 percent of whom were American Indians. Census data for 1970 showed that approximately 43,230 persons in Tulsa were 60 years and older. White elderly were 88 percent of this total, and minorities accounted for the remaining 12 percent.

The Tulsa Area Agency on Aging is responsible for planning and administering title III programs for the elderly in Tulsa. The advisory body to the Tulsa Area Agency on Aging is the Tulsa Area Council on Aging, which includes the mayor and 46 other members who are appointed by the mayor for 1 year terms. Thirty-six members were white and 11 were minority—7 of whom were black and 4 of whom were American Indian.

In 1980, the Tulsa Area Agency on Aging's staff was 50 percent minority. Two of three professional staff positions were held by minorities—one American Indian and one Asian American. As early as 1974 when the agency was established, one of two professional planner positions was held by an American Indian. The agency did not have an Hispanic or American Indian employees or any workers who were bilingual.

In 1979 (the last full funding year before the Tulsa Area Agency on Aging changed from a calendar fiscal year to the Federal fiscal year). 34.5 percent of $61,723 of the funds dispensed in Tulsa were received by two minority contractors: Native American Coalition and Tulsa Human Service Agency. There were no subcontractors in Tulsa in 1979.

Contractors in Tulsa employed from one to five program workers, few of whom were minorities. Legal Aid for Senior Citizens, Tulsa City County Health Department, Tulsa City County library (information and referral), and Jobs for Older Tulsans had no minorities in their title III funded programs. The native American coalition transportation program reported the largest number of minority staff. Hispanics were not employees and contractors in Tulsa's III–B programs.

The Tulsa Area Agency on Aging required affirmative action plans for employment/staffing, and set rates for minority participation in contracts. The Tulsa Area Agency on Aging also required that contractors sign a list of assurances that included nondiscrimination in service delivery and employment. On-site compliance reviews were conducted quarterly to assess performances in these areas. Technical assistance was provided to contractors experiencing difficulty meeting their goals for minority employment and participation.

The Tulsa Area Agency on Aging provided access, in-home, legal, health support, and employment services to elderly Tulsans. Participation statistics for these programs indicated that large numbers of elderly minority senior citizens in Tulsa remained untouched by Tulsa Area Agency on Aging services. In fact, participation data showed that minorities were generally underrepresented in the title III funded programs. American Indian elderly, in particular, received few title III services. In general, Tulsa's minority elderly population was at least twice as likely to be in poverty as the nonminority elderly population. Although the nutrition program had only recently come under the Tulsa Area Agency on Aging, participation statistics showed that minority elderly were not benefiting significantly from this program. The fact that during October through December 1980, less than 10 percent of the participants in the nutrition program were minorities, indicated minority underrepresentation in the program.

San Francisco, Calif.

In 1980, San Francisco's population was estimated at 678,974. Minorities represented more than 42 percent of the population. There also was a minority elderly population of 31,596 people (22.3 percent of elderly) in San Francisco in 1970. Minority elderly in San Francisco were more likely to be in poverty than nonminority elderly. Available statistics from the Bureau of the Census indicated that elderly Asian Americans and blacks were nearly twice as likely as elderly whites to be in poverty.

The San Francisco Commission on Aging is the area agency on aging responsible for administering programs that take into consideration the needs of San Francisco's elderly population, especially those most socially and economically in need. New commissioners, advisory council members, and an executive director of the agency were appointed in early 1981. Minorities constituted over 50 percent of the commissioners and advisory council members. The new executive director of the Commission is black. The rest of the San Francisco Commission on Aging work force was made up predominantly of white professionals and minority support staff or minority part time community workers. The San Francisco Commission on Aging adopted an affirmative action plan in early 1981. San Francisco Commission on Aging's affirmative action goals include hiring Hispanics, since they were underrepresented at the agency. However, none of the three persons hired at the agency in the past 6 months time was Hispanic.

In fiscal yar 1980–81, the San Francisco Commission on Aging distributed $2,115,612 in title III funds. Two minority contractors received 16.5 percent of the title III–B (social services) funds: Self Help for the Elderly, a Chinese American organization, and Mission Neighborhood Centers, an Hispanic organization. Five nonminority contractors received 83.5 percent of the title III–B funds. American Indian, Black, Japanese American, or Filipino American organizations did not receive any funds under title III–B for fiscal year 1980–81. In addition to the seven contracts awarded for Title III–B, San Francisco Commission on Aging funded eight nutrition contracts under Title III–C, totaling $1,524,161. One black contractor, one Chinese American, one Japanese American, one American Indian, and four nonminority contractors received title III–C funds in fiscal year 1980–81. The four nonminority organizations received $1,035,752 or 68 percent of the title III–C funds awarded. Hispanic and Filipino American organizations did not receive any title III–C funds in fiscal year 1980–81.

In fiscal year 1981–82, all contractors were to be funded at 91 percent of their previous year's funding, with the remaining money to be used to bring new contractors into the funding stream and to improve existing services in some areas. Minority contractors were concerned that the cut in funding would hurt them most, since they had small contracts and could less easily absorb a 9-percent cut in funding. They also note that the money made available for new contracts would not be enough to fund new contractors adequately. The additional contracts for fiscal year 1981–82 were awarded to seven minority and four nonminority firms. Most of the contracts were for less than $15,000.

Minority employees of the title III contractors generally did not hold decision-making positions except when they were employed by minority contractors. No affirmative action plans were required of Title III–B contractors until 1981. Some nonminority organizations did not have bilingual staff, or literature in languages other than English.

The participation of minority elderly in title III programs varied greatly. Looking at each of the services individually, the data showed that minorities were much more likely to benefit from certain ones than from others, and there appeared to be a direct relationship between minority participation and whether the firm providing the service was minority. Title III contractors lacked extensive outreach to minorities. The contractors indicated that they were serving up to capacity now and did not encourage further participation because of budget constraints. San Francisco Commission on Aging has not monitored and evaluated programs regarding minority participation. It did not encourage contractors to do more outreach so that minorities could participate in the available programs.

Honolulu, Hawaii

Asian and Pacific Island Americans represent nearly 73 percent of the residents of Honolulu. Japanese and Hawaiians are the two largest Asian groups. More than 72,000 persons in Honolulu were 60 years of age or older, and almost 73 percent of them were Asian and Pacific Island Americans. Statistics also showed that the elderly population of Honolulu was less well off economically than the general population and that Filipino elderly, in particular, were more likely to be in poverty. Although Asian and Pacific Island elderly experience the same age-related problems as other older persons, their problems were complicated by cultural and linguistic factors. The special interests and needs of Honolulu's elderly, especially those most socially and economically disadvantaged, were to be addressed by the federally funded Honolulu Area Agency on Aging.

The Honolulu Area Agency on Aging operates with an advisory council—the Honolulu Committee on Aging—which had 18 members. Japanese accounted for 39 percent of the committee's membership. Chinese held 22 percent of the committee positions while Hawaiians represented 11 percent of the committee's membership. The racial and ethnic composition of the Honolulu Area Agency on Aging staff was similar to that of the committee on aging. Four of the six professional staff positions were filled by Japanese, while two positions were held by Chinese. Hawaiians were represented in clerical and paraprofessional positions; Filipino representation was limited to aide positions. The Honolulu Area Agency on Aging placed little emphasis on language qualifications for staff although a significant proposition of the elderly population served by the Honolulu Area Agency on Aging was non-English speaking. As a result, many community representatives voiced concern that the Honolulu Area Agency on Aging did not effectively serve certain elderly ethnic groups because of language communication difficulties. According to representatives of the Susannah Wesley Community Center, the agency was especially unable to serve new immigrant groups such as Koreans, Samoans, and Indochinese. Since there was a very low turnover rate at the Honolulu Area Agency on Aging, there were few new hires and few promotions. In addition, although the Honolulu Area Agency on Aging is part of the Honolulu Office of Human Resources which does have an affirmative action plan, there was no separate affirmative action plan in effect for the Honolulu Area Agency on Aging.

In fiscal year 1980–81, six title III contracts were awarded by the Honolulu Area Agency on Aging. None of the six contractors was minority. Three of the agencies were nonprofit public service agencies administered by boards of directors, each with a majority white membership. Only the title III–C (nutrition) contractor subcontracted. Two of the five meal providers with nutrition subcontracts were minority organizations. Staff employed by the title III contractors was composed predominantly of Asian and Pacific Island Americans. Persons of Japanese and Chinese backgrounds, however, were more likely to be employed by the contractors in administrative level positions than Hawaiians or Filipinos. In contrast, Filipinos and Hawaiians were more likely to be represented in service worker positions than any of the other groups.

Although the Honolulu Area Agency did not stress the need to hire bilingual staff and believed that there were few communication difficulties with minority older persons since everyone spoke "pidgin," all except one of the contractors did take bilingual capabilities into consideration when hiring. One contractor included bilingualism as an overall job requirement. Contractors also stated that the Honolulu Area Agency on Aging did not impress upon them the need to take into consideration the diverse cultural backgrounds of the elderly people that they served.

The Honolulu Area Agency on Aging required contractors to submit monthly reports as well as affirmative action plans. Most contractors indicated, however, that the Honolulu Area Agency on Aging did not enforce the requirement that contractors submit the race or ethnicity of program participants.

The available statistics on program participants showed that, in general, Hawaiian elderly were underserved when compared with their representation within the elderly population. In particular, the chairperson for the office of Hawaiian affairs voiced concern about the low number of Hawaiians taking part in the nutrition program. Representatives from Alu Like and other Hawaiian interest groups also pointed to the limited number of Hawaiian elderly participating not only in the nutrition program, but also in all the title III services.

Title III contractors, as well as representatives of other organizations that serve elderly persons, emphasized the absence of culturally responsive services, particularly in the nutrition program. Nearly 90 percent of the participants in the program were Asian and Pacific Island Americans whose meal preferences and problems with the current meal service delivery had been documented. Although four of the five meal service providers took into consideration the ethnic diversity of the participants in the nutrition program when preparing menus, one provider did not. That one provider, however, prepared more than 87 percent of all meals served in the program. Although Honolulu Area Agency on Aging was aware of this, the agency had made no plans to recommend that the contractor change menu selections.

Title III service programs generally did not use outreach efforts that could increase participation of the elderly. The lack of information about program services, particularly in languages other than English, hindered the recruitment of non-English-speaking seniors for programs.

ITEM 15. COMPTROLLER GENERAL OF THE UNITED STATES (GENERAL ACCOUNTING OFFICE)

DECEMBER 8, 1981.

DEAR MR. CHAIRMAN: In response to your committee's September 10, 1981, request for information concerning programs and services for the elderly, we are enclosing a statement of our internal activities which involve the elderly (enclosure I). We have, also included a list of reports issued during fiscal year 1981 and the first 2 months of fiscal year 1982 (enclosure II); and a list of current assignments (enclosure III) which relate to programs and services for the elderly.

Copies of the issued reports are being provided to your office separately. A summary of the major findings and conclusions for each report is included in a digest bound in each report or in the letter transmitting it.

Sincerely yours,

GREGORY J. AHART, *Director.*

Enclosures.

ENCLOSURE I.—*General Accounting Office Internal Activities Which Involve the Elderly*

Equal employment opportunity and merit promotion, two programs covered by GAO orders, provide the basis for our policy regarding employment of the elderly. From the prohibition of discrimination on the basis of age in employment and in selection for job vacancies, other policies and practices evolve. For instance, because training is important to enhance effectiveness and provide opportunities for advancement, older employees are included in opportunities for training, both in-house and outside the agency.

In keeping with our policy of nondiscrimination, persons over 40 are recruited for available positions with the Office. Although an employment freeze limited our recruitment during the year, as of October 15, 1981, 498 persons have been appointed to permanent and temporary positions this year. Of that number, 21 persons were age 40 and older at the time of their appointment.

As of October 15, 1981, 1,687 persons age 40 and older (33.2 percent of our work force) are on the rolls of the General Accounting Office. Although employees in this age group participate widely in all our programs, we especially note that we have three employees age 40 and older in the upward mobility program and two in our cooperative education program. These programs usually draw participants from a younger population.

The employee health maintenance examination, a comprehensive and professional medical examination, is available on a 2-year cycle for all employees age 40 and older. Employees nearing retirement age have available individual preretirement counseling. The Office of Organization and Human Development provides semiannual preretirement seminars. Our civil rights office also provides information and advice to persons regarding complaints of alleged discrimination because of age.

ENCLOSURE II.—*General Accounting Office reports issued which concern the elderly*

Title of report	*Date*
The Social Security Administration's Beneficiary Rehabilitation Program (HRD–81–22).	Nov. 10, 1980.
Review of Alleged Questionable Actions by EDSF to Reduce its Claims and Correspondence Backlogs Under its Medicare Contract in Illinois (NRD–81–44).	Dec. 16, 1980.
Reissuing Tamper-Resistent Cards Will Not Eliminate Misuse of Social Security Numbers (HRD–81–20).	Dec. 23, 1980.
HHS Should Improve Monitoring of Professional Standards Review Organizations (HRD–81–26).	Dec. 29, 1980.
Programs to Control Prescription Drug Costs Under Medicaid and Medicare Could be Strengthened (HRD–81–36).	Dec. 31, 1980.
Implementing GAO's Recommendations On The Social Security Administration's Programs Could Save Billions (HRD–81–37).	Dec. 31, 1980.
Millions Can Be Saved By Identifying Supplemental Security Income Recipients Owning Too Many Assets (HRD–81–4).	Feb. 4, 1981.
Analysis of Proposed New Standards For Nursing Homes Participating in Medicare and Medicaid (HRD–81–50).	Feb. 20, 1981.
Information on Dine-Out Feature of the Food Stamp Program (CEDD–81–72).	Feb. 27, 1981.
What Can Be Done To Check The Growth of Federal Entitlement and Indexed Spending? (PAD–81–21).	Mar. 3, 1981.
More Diligent Followup Needed To Weed Out Ineligible SSA Disability Beneficiaries (HRD–81–48).	Mar. 3, 1981.
Action Needed to Resolve Problem of Outstanding Supplemental Security Income Checks (HRD–81–58).	Mar. 3, 1981.
Keeping the Railroad Retirement Program on Track—Government and Railroads Should Clarify Roles and Responsibilities (HRD–81–27).	Mar. 9, 1981.
Revising Social Security Benefit Formula Which Favors Short-Term Workers Could Save Billions (HRD–81–53).	Apr. 14, 1981.
An Evaluation of the Organizational Relationship of the Office of Human Development Services And The Administration on Aging (FPCD–81–41).	Apr. 20, 1981.
Response to the Senate Permanent Subcommittee on Investigations' Queries on Abuses in the Home Health Care Industry (HRD–81–84).	Apr. 24, 1981.
VA's Home Care Program Is a Cost-Beneficial Alternative To Institutional Care and Should Be Expanded, but Program Management Needs Improvement (HRD–81–72).	Apr. 27, 1981.
Information On Persons 60 Years or Older Employed By Area Agencies On Aging (HRD–81–81).	Apr. 27, 1981.
Weaknesses In The Planning And Utilization Of Rental Housing For Persons In Wheelchairs (CEDD–81–45).	June 19, 1981.
More Can Be Done To Improve The Department Of Agriculture's Commodity Donation Program (CEDD–81–83).	July 9, 1981.
Ohio's 1981 Home Energy Assistance Program (HRD–81–122)	July 15, 1981.
Limits On Receipt Of Multiple Disability Benefits Could Save Millions (HRD–81–127).	July 28, 1981.
Impediments To State Cost Saving Initiatives Under Medicaid (HRD–81–121).	July 29, 1981.
More Action Needed To Reduce Beneficiary Underpayments (HRD–81–126).	Sept. 3, 1981.
Medicare's Reimbursement Policies For Durable Medical Equipment Should Be Modified And Made More Consistent (HRD–81–140).	Sept. 10, 1981.
Delays In Receiving And Investing Taxes Are Reducing Railroad Retirement Program Interest Income (HRD–81–112).	Sept. 24, 1981.
Medicare Home Health Services: A Difficult Program to Control (HRD–81–155).	Sept. 25, 1981.
State Veterans' Homes: Opportunities To Reduce VA And State Costs And Improve Program Management (HRD–82–7).	Oct. 22, 1981.

Improved Knowledge Base Would Be Helpful In Reaching Policy Decisions On Providing Long-Term, In-Home Services For The Elderly (HRD-82-4).	Oct. 26, 1981.
Uncertain Quality, Energy Savings, And Future Production Hamper The Weatherization Program (EMD-82-2).	Oct. 26, 1981.
More Specific Guidance And Closer Monitoring Needed To Get More From Funds Spent On Social Services For The Elderly (HRD-82-14).	Nov. 12, 1981.

Enclosure III.—*General Accounting Office audits in process which concern the elderly*

A Review of Federal Efforts to Improve Transportation in Rural Areas.[1]

Survey to Determine Issues Concerning Age Discrimination.[1]

Review of Tax Exempt Home Health Agencies.[1]

Review of the Use of Existing Data Files for Oversight.[1]

Review of the Effects of Home Health Care on Hospitalization Characteristics.[1]

Review of Medicaid Reimbursement and Nursing Home Bed Supply: An Analysis of Multi-year Survey Data.[1]

A Review of Tax Credits to Take Care of Elderly In-Home.[1]

Survey of Mental Health Services Provided to the Elderly.

Establishing a Comprehensive, Coordinated System of Services for Older Americans.[1]

Survey of Social Security's Actuarial Projections.

Review of Social Security Benefits for Spouses and Dependents.[1]

Review of Benefits to Divorced Spouses Under the Social Security Act.

Survey of Benefits for Unaged Parents.

Survey of Early Retirement Reduction and Pro-Rata Benefit Payment.

Survey of the Social Adequacy Elements in the Social Security Program.

Review of the Currently Insured Provision.

Survey of Exempt Wages and Amounts.

Survey of the Railroad Retirement Board's Unemployment and Sickness Program.

Survey of Social Security Payments to Beneficiaries Living Overseas.[1]

Review of State Death Information on Federal Income Security Programs.

Review to Assess the Advantages and Disadvantages of Paying Benefits on a Basis Similar to that Used When Workers take Early Retirement.

Survey of SSA's System for Resolving Problems in the Retirement, Survivors, and Disability Programs.

Survey of Placing Liens on Property Owned by Public Assistance Recipients.

Treatment of Income Tax Paid, Refunds Received, and the Effect of the Earned Income Tax Credit in Needs Based Programs.

Survey of Representative Payees in Federal Programs.[1]

Survey of the Supplemental Security Income Redetermination Process.

Review of Rural Health Clinics.[1]

Survey of Medicaid's Quality Control Program.

Survey of Medicare and Medicaid Utilization Controls for Physician Reimbursement.

Review of Fixed-Price Contracting Experiments in Medicare.[1]

Review of Durable Medical Equipment.[1]

Survey of Reimbursement Practices in End-Stage Renal Disease Program.

Survey of Utilization Controls Over Hospital Ancillary Services.

Survey of Medicaid Free Choice Provision for Hospital Services.

Survey of Medicare Payments Made to Group Practice Prepayment Plans.

Review of Nonarms Length Transactions Between Hospitals and Related Entities.

Survey of S/UR II Subsystem for Medicaid Utilization Review.

Survey of Development of Intermediate Care Facilities for the Mentally Retarded.

Medicare Underpayments by Electronic Data Systems Federal (EDSF) in Illinois.[1]

---

[1] Being performed at the request of committees or individual Members of Congress.

ITEM 16. ENVIRONMENTAL PROTECTION AGENCY

JANUARY 8, 1982.

DEAR MR. CHAIRMAN: I am pleased to respond to your request of September 10, 1981, and inform you of the continuing success of older worker activties at the Environmental Protection Agency (EPA).

The Senior Environmental Employment (SEE) Corps was created in concert with State environmental agencies and the financial aid of the Administration on Aging, Department of Health and Human Services. The Corps has provided meaningful part-time employment to several hundred older Americans in jobs relating to the prevention, abatement, and control of environmental pollution. The jobs include surveying toxic chemicals used in industrial areas, educating the public on areawide water quality planning, establishing and enforcing noise abatement control programs, establishing and managing agency environmental libraries, presenting education programs on the use of pesticides and the hazards of poisoning to farmworkers, and working on surveys of environmental carcinogens.

For example, our Office of Monitoring Systems and Quality Assurance has found that using older workers in crisis situations, such as Three Mile Island and Love Canal, lessens the problems of creating a special work force to meet such circumstances. Under the SEE Corps, qualified older workers can be recruited on short notice to assist in work to be done in similar crises.

In addition, the Office of Noise Abatement and Control has developed a cadre of senior citizens to combat noise pollution. Some are volunteers who serve as noise counselors in 50 or more communities throughout the country. Other older workers, who are paid either by Department of Labor title V or EPA funds, serve as noise representatives, giving technical assistance to States and communities or assisting in noise surveys and public education.

EPA also has a SEE Corps group whose responsibility is working with the States in training school personnel on what to look for and how to test for asbestos contamination in schools. Yet another SEE Corps program deals with solid and hazardous waste disposal methods. The senior citizens work with Federal, State, and local governments, and civic organizations to establish proper disposal procedures for the waste.

EPA has supported other activities of title V, including older worker programs in Florida, Alabama, California, Iowa, and Washington. In addition, the Agency has helped to support a poison alert project staffed by older workers in the States of California, Washington, and Iowa. Other States conducted noise surveys and studies, and in the State of Washington, older workers are monitoring landfills to measure the gases seeping from underground to the surface.

For the past several years, the Congress has sponsored a bipartisan program designed to acquaint selected senior citizens with the working of the legislative branch. This program, called the congressional senior citizen intern program, has historically included information sessions with several executive branch agencies who have programs on aging. As a result of the success of the SEE Corps, this year EPA was asked to participate in the program. The program provided EPA with an excellent opportunity to acquaint the 350 or so distinguished older Americans with the hostory, objectives, and goals of the Agency, as well as the opportunities that the SEE Corps can afford them and their fellow senior citizens.

Also as a result of the success of the SEE Corps, EPA and its State counterparts are making efforts to expand the program. The SEE Corps will ultimately operate in the eight program office areas and in all 50 States. To help publicize the SEE Corps, we have developed a short film entitled, "SEE—It's Working." It relates how the States have benefited from the talents and skills of older workers and the way SEE Corps members feel about their participation in the programs and the work they are doing.

In addition, EPA assisted the American Association of Retired Persons in a miniconference of the 1981 White House Conference on Aging, addressing the Environment and Older Americans. The miniconference was held in February 1981, in Washington, D.C. The resolutions were presented to the 1981 White House Conference on Aging in November.

We believe that the SEE Corps provides excellent opportunities for older citizens to participate in and benefit from the program while improving environmental quality for everyone.

Sincerely yours,

ANNE M. GORSUCH, *Administrator*.

ITEM 17. FEDERAL COMMUNICATIONS COMMISSION

JANUARY 8, 1982.

DEAR MR. CHAIRMAN: This is in response to your letter of September 10, 1981, requesting fiscal year 1981 information regarding initiatives or programs by this Commission that impact either directly or indirectly on the elderly.

The Federal Communications Commission has the mandate to regulate communications "to make available, so far as possible, to all the people of the United States a rapid, efficient, nationwide, and worldwide wire and radio communication service." 47 U.S.C. § 1. Consequently, our actions are generally broadly based and do not focus directly upon the needs of the elderly.

During the past several years, this Commission has assisted in the initiation of efforts to provide closed captioning of television for the Nation's deaf and hearing impaired. Since a significant proportion of all persons with bilateral hearing losses are aged 65 or older, consideration of telecommunication needs of the deaf is a matter of interest to the elderly, although not specifically directed to the elderly. Presently, PBS, ABC, and NBC are providing 20 hours of captioned programing per week.

Most recently, the Commission issued a notice of proposed rulemaking authorizing television stations to provide teletext data transmission services. The proposal would allow the use of line 21 of the television screen, on an equal access basis, with closed captioning transmissions for the hearing impaired. Teletext systems have the potential to serve a wide variety of applications, including closed captioning for the hearing impaired, weather reports, comparative shopping services, news and community services bulletins.

Additionally, the Commission has adopted a rule allocating frequencies to provide for operation of tactile paging devices for the deaf, blind, or physically handicapped. A person can be paged by means of a device that vibrates. The paged person can then use the device to transmit an acknowledgement.

As a result of our initiative to identify the telecommunications needs of the deaf, A.T. & T. has filed tariffs with the FCC providing for an all-day reduction in rates for hearing-impaired individuals using the teletypewriter for the deaf (TTY).

Other than the efforts described above, the Commission has not expended funds during fiscal year 1981 on specific programs for the elderly. We do, however, envision that many of our efforts permitting new technology introductions will provide greater uses of telecommunications services which will be of benefit to the elderly community.

I hope this information will be of assistance to your committee and I appreciate the opportunity to respond.

Sincerely,

MARK S. FOWLER, *Chairman.*

ITEM 18. FEDERAL TRADE COMMISSION

DECEMBER 18, 1981.

DEAR MR. CHAIRMAN: I am pleased to forward the enclosed staff summary of Federal Trade Commission activities affecting the elderly for the year 1981. As this enclosure indicates, many of the Commission's efforts to promote a free and fair marketplace are particularly significant for elderly consumers.

I hope this information will be helpful to the committee. Please let me know if we can provide any further assistance.

By direction of the Commission.

JAMES C. MILLER III, *Chairman.*

Enclosure.

STAFF SUMMARY OF FEDERAL TRADE COMMISSION ACTIVITIES AFFECTING THE ELDERLY

VISION CARE

Over 90 percent of persons over the age of 65 wear corrective lenses. The FTC has two programs designed to lower the price of vision care. The first, the "Eyeglasses Rule," gives consumers the right to obtain a copy of their prescription after having their eyes examined, thereby enabling them to comparison shop for eyeglasses.

The second vision care program, known as "Eyeglasses II," is examining several proposals aimed at increasing competition and lowering prices in the vision care market. One portion of the investigation is focused on restrictions which inhibit so-called "commercial" practice of optometry, including restrictions which prevent optometrists from practicing under a trade name, working for a lay corporation, locating their practice in a commercial location, and operating branch offices. In addition, the FTC is examining staff proposals to expand the prescription release requirement contained in the Eyeglasses I Rule. These proposals would give consumers the right to: (1) Retain a copy of their eyeglasses prescription after it is filled; and (2) obtain a copy of their complete contact lens prescription at the conclusion of the fitting and dispensing process. If adopted they would enable consumers to comparison shop for duplicate or replacement pairs of eyeglasses or contact lenses.

DENTAL CARE

Slightly over half of all persons over age 65 have lost their teeth, and approximately half of this group needs denture care, either because they have no dentures at all or because the dentures they do have are so ill-fitting as to be beyond repair. The high cost of denture care and the maldistribution of dentists in certain parts of the country (most notably in rural and inner-city areas) may prevent elderly consumers from obtaining denture care. Preliminary evidence from Canada suggests that consumer costs may decrease and access to denture care may increase where dental laboratory technicians, known as "denturists," are permitted to provide dentures directly to consumers. In the United States virtually all States prohibit nondentists from selling dentures directly to patients and require that dentures be fitted only by dentists. The FTC is gathering evidence to determine the potential effects on consumers of permitting denturists to offer their services directly to the public.

PRESCRIPTION DRUGS

Persons over the age of 65 comprise 11 percent of the population, but pay 25 percent of the national prescription drug bill. Consequently, savings on prescription drug purchases are especially significant for elderly consumers. In 1979, the FTC staff completed an examination of State laws which prevent pharmacists from substituting lower cost generic drugs for brand name pharmaceuticals, and concluded that modification of these State laws could result in significant consumer benefits, with no compromise in the quality which consumers receive. The Commission's staff in conjunction with the Food and Drug Administration proposed a model drug product selection statute for consideration by the States, and the staff continues to provide assistance to States contemplating legislation on this issue.

Several States have adopted the model law, in whole or part. The Commission's Bureau of Economics has just begun an investigation to determine if consumers in States that have adopted the model have enjoyed the benefits the law was designed to provide.

HEARING AIDS

The majority of hearing aids are purchased by the elderly. Statistics indicate that over 40 percent of persons over 65 have some type of hearing impairment. In 1975, the Commission began a rulemaking proceeding dealing with the advertising and sale of hearing aids. In its current form, the rule would give the consumer a 30-day trial option which enable him or her to evaluate the aid and return it if it proved unsatisfactory. The principal purposes of this provision are to discourage manufacturers and sellers from overstating the value of hearing aids, to discourage high pressure sales tactics, and to protect consumers from the risk inherent in the purchase of a hearing aid that the aid will not provide a benefit. Staff expects to present the proposed rule to the Commission for its final consideration in early 1982.

COMPETITION IN THE HEALTH CARE SECTOR

The following projects are aimed at preventing anticompetitive conduct in the health care industry. Their purpose is to stimulate and strengthen competitive forces in the industry, thereby decreasing the need for Government regulation, increasing consumer choice among providers of health care services, improving quality, and lowering the cost of health care. Consumers aged 65 and older spend almost three times as much on health care per capita as do consumers aged 19 to 64. Since many persons over 65 have fixed incomes, these Commission initiatives may have a significant impact on elderly consumers.

American Medical Association (AMA).—In October 1979, the Commission issued a decision in its case against the AMA. The Commission found that the AMA had imposed illegal restrictions on truthful advertising by physicians and medical organizations and on the ability of physicians to work on a salaried basis for hospitals and health maintenance organizations. The Commission ordered the AMA to stop imposing such restrictions. Pursuant to the decision, physicians will be able to provide consumers with truthful information about the services they offer, including information of critical importance to older Americans—e.g., prices for routine services, office hours, whether they accept medicare reimbursement, whether they offer discounts for the elderly, whether they make house calls, and whether they are accessible by public transportation. Hospitals and HMO's will be able to seek to hold down costs by employing physicians on a salaried basis. The Commission's order expressly provides that the AMA may adopt reasonable ethical guidelines to prevent false and deceptive advertising. The Commission's order was upheld, with minor modification, by the U.S. Court of Appeals for the Second Circuit in October 1980. The matter is currently on appeal before the U.S. Supreme Court. A decision is expected by summer 1982.

American Dental Association (ADA).—In September 1979, the Commission issued a decision and order accepting the terms of a consent agreement by which, in essence, ADA agreed to be bound in its conduct by the terms of the AMA decision described above, as finally determined by the courts of appeal. This order permits dentists to advertise such services as fitting dentures, and can bring older patients the benefits of price competition.

Michigan State Medical Society.[1]—On July 27, 1979, the Commission issued a complaint alleging that the society's members conspired to fix prices and to boycott cost-containment procedures instituted by the Michigan Blue Shield Plan. The trial of this case has been completed and an initial decision was issued by the administrative law judge in June 1981, upholding the complaint's allegations and prohibiting future similar conduct. The decision is currently on appeal to the Commission.

Indiana Federation of Dentists.[1]—On October 18, 1978, the Commission issued a complaint alleging that the Indiana Federation of Dentists obstructed cost-containment measures instituted by insurers. The initial decision, which upheld the allegations in the complaint, is on appeal to the Commission.

Sherman A. Hope, et al.—On July 30, 1980, the Commission issued a complaint charging the five doctors practicing in Brownfield, Tex., with threatening to boycott the local hospital if it hired a new doctor on financial terms unacceptable to them. The hospital, the only one in the county, had tried to recruit a new doctor into the area by offering him a guaranteed minimum income. According to the complaint, the doctors threatened not to perform their emergency room and administrative jobs at the hospital and not to deal professionally with the new doctor. A proposed consent agreement to refrain from such conduct in the future became final on August 5, 1981.

American Medical International.[1]—On July 31, 1981, the Commission issued a complaint alleging that AMI's acquisition of French Hospital in San Luis Obispo County, Calif., which gave AMI control of 68 percent of the hospital beds in the county, was likely to substantially lessen competition in that area, and constituted an attempt to monopolize the delivery of acute-care hospital services in the county. The case is currently in pretrial preparation.

Physician control of medical prepayment plans.—The Commission has been conducting a substantial investigation into the extent and effects of agreements by groups of physicians to form, control, operate, or otherwise seek to influence medical prepayment plans (such as Blue Shield plans and HMO's). Such plans make decisions that can significantly affect competition among providers of health care services. For example, they decide how much to pay physicians, what cost containment measures to use to control the price and utilization of health care services, and whether or on what terms to reimburse providers of health care who are not physicians. When a physician group controls a plan, such decisions might be made with the intent or effect of lessening competition faced by the physicians, and thus could result in higher prices, the unreasonable exclusion of competing providers of health care (which limits consumer choice and harms the competitors), or other anticompetitive effects.

---

[1] This matter is currently in litigation, and the Commission expresses no view whatever as to the merits of the case.

In April 1981, the Commission decided to proceed on a case-by-case basis in addressing the antitrust implications of physician control of medical prepayment plans rather than to propose an industrywide rule, as had been considered earlier. On September 25, 1981, the Commission adopted an enforcement policy with respect to physician agreements to control medical prepayment plans. 46 Fed. Reg. 48982 (1981). The statement explains the analysis and priorities the Commission intends to use in its law enforcement program relating to physician-controlled plans.

MOBILE HOME SALES AND SERVICE

Mobile homes comprise a substantial portion of the low- and moderate-income housing stock, and a large proportion of mobile homeowners are elderly persons. In August 1980, the FTC issued a staff report recommending adoption of a proposed trade regulation rule designed to improve warranty service on mobile homes. Although nearly all new mobile homes are sold with a written warranty, evidence gathered in this rulemaking proceeding indicates that service under these manufacturers' warranties is inadequate, delayed, or simply refused for as many as 40 percent of owners of new mobile homes who request such service. In its report, the staff recommended a rule that would set 30-day time limits within which mobile home manufacturers or their service agents must complete warranty repairs. It would also require manufacturers to perform preoccupancy inspections of homes. In addition, the recommended rule would require that manufacturers have systems designed to improve their monitoring of how dealers and other service agents perform warranty repairs.

CREDIT

The FTC enforces the Equal Credit Opportunity Act, which prohibits discrimination on the basis of a number of factors, including age. While Federal law permits a creditor to consider information related to age, credit cannot be denied, reduced, or withdrawn solely because an otherwise qualified applicant is over a certain age. Furthermore, retirement income must be included in rating a credit application and credit may not be denied or withdrawn because credit-related insurance is not available to person of a certain age.

NURSING HOMES

It has been estimated that three-fourths of all nursing home residents are 75 years and older. The FTC staff has been examining the business practices of nursing homes as they affect the approximately one-third of the Nation's nursing home residents who pay directly for their own care. Although the industry is heavily regulated by Federal, State, and local governments, these regulations generally focus on health and safety rather than protection of consumers' economic interests. Staff is particularly interested in the information disclosed to residents before entering a home.

MEDICARE SUPPLEMENT INSURANCE

More than 50 percent of the Nation's elderly have at least one private health insurance policy to supplement their medicare coverage. Consumers have complained that a variety of problems connected with the sale of medicare supplement insurance exist, including: Confusing policy provisions that inhibit effective comparison shopping; exploitative sales practices that focus on the special vulnerability of the elderly; the sale of policies that duplicate existing coverage; and low rates of return (expressed as the ratio of benefits paid to premiums collected). In 1979, the FTC initiated a study to determine what types of regulatory schemes are most effective in combating these problems. FTC staff is now cooperating with the Department of Health and Human Services in a study of State medicare supplement regulations.

FUNERALS

Since 1975, the FTC has been conducting a rulemaking proceeding that could affect the almost 2 million persons who arrange funerals each year, including numerous elderly citizens. The Commission tentatively approved in substance a proposed rule in March 1979. Subsequently, the FTC Improvements Act of 1980 placed specific limits on the scope of any final rule. The act required that the funeral rule be revised in accordance with these limits and that the revised rule be published for public comment prior to determining whether or not to adopt a final rule. In January 1981, the Commission published a revised rule for a 60-day public comment period and a 50-day rebuttal period. On July 22, 1981, the Commission voted to approve the rule language for submission to the Office of Management and Budget, which will review the rule's recordkeeping requirement. Final Commission action on the rule is expected upon completion of the OMB review process.

The revised funeral rule is intended to increase consumer access to accurate information prior to and at the time of purchase. The role would: Require funeral directors to disclose itemized price information; prohibit misrepresentations of legal and cemetery requirements and the preservative or protective value of embalming, caskets, and vaults; and prohibit funeral directors from engaging in certain practices, such as requiring a casket for cremation and embalming without express permission.

DELIVERY OF LEGAL SERVICES

The Commission's staff is currently conducting an investigation to determine whether various public and private restrictions have hindered the development of legal clinics and closed-panel third-party payment plans for legal services. Legal clinics and closed-panel plans reputedly offer reduced fees and increased access to high quality legal services. These advantages may be of particular benefit to the elderly, whose income often exceeds limits established by Government-sponsored assistance programs, yet may be insufficient to cover the high costs of private bar assistance.

ITEM 19. LEGAL SERVICES CORPORATION

OCTOBER 8, 1981.

DEAR MR. CHAIRMAN: In response to your letter of September 14, 1981, the Legal Services Corporation is pleased to report on its services and benefits offered to older Americans.

As you know, the Legal Services Corporation was established by Congress in 1974 to provide financial support for civil legal assistance to poor people. The Corporation presently funds over 320 legal services programs around the country which provide legal assistance to the general poverty population. Because the elderly are found in disproportionate numbers within the poverty population, they are a major target for the provision of legal services.

Eligibility for legal services is governed by income and resources. The Corporation, as required by statute, has established a maximum income level—125 percent of the OMB poverty line—for the receipt of legal services and has set forth factors which local programs must take into consideration in developing their own eligibility guidelines. Within these parameters, each program has established procedures for determining the eligibility of applicants for legal services.

Similarly, priorities for the types of legal problems which will be addressed by local programs (again, within the parameters of the Legal Services Corporation Act and regulations) are determined on a local level, based on the legal needs of the particular community to be served. Thus, although the elderly poor are generally eligible for Corporation-funded legal services, one must look to the specific program's guidelines as to the types of cases handled and the actual financial eligibility requirements for that particular area.

While most local legal services programs do not exclusively serve older Americans—the elderly poor are served along with all low-income persons—many programs have separate units to address the special legal problems of the elderly. This has often been made possible through the joint funding of such specialized elderly units by the Legal Services Corporation and the Administration on Aging. The Older Americans Act funding has enabled the legal services programs to undertake additional efforts on behalf of the elderly, such as outreach and community legal education, with a concomitant increase in the quantity and quality of services to the elderly.

The Corporation also funds the National Senior Citizens Law Center, a national center to provide support and technical assistance to local program staff on the legal issues unique to the elderly population. The center has provided training and developed manuals in close consultation with elderly advocates and clients. The center undertakes litigation on issues of concern to elderly clients as well as provides administrative and legislative representation to these clients in Washington, D.C. The center also communicates on a regular basis with elderly groups to keep them informed of the latest developments in elderly law.

Last year, the Legal Services Corporation completed a nationwide study of the special legal problems of the elderly and of their special problems in obtaining access to legal services. The results of this study have been useful in developing the Corporation's future plans for meeting our goal of providing high quality legal assistance and assuring equal access to our system of justice for the redress of grievances for those otherwise unable to afford adequate legal counsel.

Although actual expenditures on service to the elderly are difficult to determine with any precision, statistics gathered during the above-mentioned study do provide a basis for comparison. The study found that the median program had a caseload containing 13.9 percent elderly clients.

In 1977, the Corporation and the Administration on Aging (AoA) entered into an agreement, the purpose of which was to encourage cooperative relationships between the Legal Services Corporation-funded programs and AoA-funded projects and agencies at the State and local level. Under the aegis of this statement of understanding, as the agreement is entitled, the Corporation and AoA had worked cooperatively on a number of efforts to benefit the low-income elderly population. Unfortunately AoA recently terminated an existing agreement with the Corporation for the utilization of Corporation employees by AoA to assist with the development of legal services activities authorized and funded under the Older Americans Act. These employees had served as the Corporation's liaison in the implementation of the statement of understanding between the two agencies. AoA informed the Corporation that there was no longer any need for assistance to encourage the development of legal services and that they were terminating or modifying their legal services-related activities at the national level. The Corporation is concerned that this decision is an indication that AoA is abandoning its commitment to the development of quality legal assistance for older persons. The Corporation has maintained the liaison staff to continue working on the further development of elderly legal services, and we have notified AoA of our continued willingness to assist them in this endeavor as well.

I hope this information will be helpful to you. If I can be of any further assistance, please do not hesitate to contact me.

Sincerely,

DAN J. BRADLEY, *President.*

ITEM 20. NATIONAL ENDOWMENT FOR THE ARTS

JANUARY 19, 1982.

DEAR MR. CHAIRMAN: I am pleased to report to you on the fiscal year 1981 activities of the National Endowment for the Arts concerning arts programing that involves older Americans.

The Endowment has taken a number of important steps to assure links between the arts and older persons. As a result of Endowment initiatives, the arts became an integral part of the White House Conference on Aging (WHCoA); this resulted in first time WHCoA resolutions on the arts and humanities. Enclosed is a list of resolutions from the WHCoA Continuing Community Participation Committee.

Working in partnership with the Administration on Aging, the WHCoA and the National Endowment for the Humanities, we sponsored a Symposium on the Arts, the Humanities, and Older Americans that was held in Philadelphia, Pa., February 1-3, 1981. Convened by the National Council on Aging, this conference brought together 80 artists, scholars, and specialists in the fields of aging to develop a report that became part of the working papers of WHCoA.

In order to further illustrate for Conference participants the value of the arts, the Endowment sponsored a visual arts exhibit entitled "Patina," which featured works by five older artists. As I stated in my remarks at the opening ceremonies, "Although there have been three previous White House Conferences on Aging, this is the *first* time that the arts have been addressed and highlighted in such a manner. This should prove to be a significant step in achieveing public awareness of the long-term contributions of artists, as well as of the value of the arts, in enriching the lives of older adults." We were pleased that three of the artists attended the opening, including Jacob Lawrence, a member of our

National Council on the Arts. Also enclosed is a copy of the catalog that details the work of these outstanding artists.

Intergenerational communication through the arts greatly contributes to the vitality of the arts and the community—a vitality that is strengthened immeasurably by the participation of older people. This agency's concern and commitment to the full participation of all citizens in the arts is not only reflected in its major goals, but also in its advocacy and support for older Americans as outlined in the attached report.

I hope that you find this information helpful. Please advise me if I may be of further assistance.

Sincerely,

F. S. M. HODSOLL, *Chairman.*

Enclosures.

SUMMARY OF ACTIVITIES RELATING TO OLDER AMERICANS, FISCAL YEAR 1981

The major goals of the National Endowment for the Arts are to foster professional excellence of the arts in America "* * * and equally to help create a climate in which they may flourish so that they may be experienced and enjoyed by the widest possible public." It it this context that the Endowment has encouraged access to the arts for older people.

The National Endowment for the Art has long been concerned that the arts be made available to as many Americans as possible. This is reflected in the 1973 resolution of our National Council on the Arts: "No citizen should be deprived of the beauty and insights into the human experience that only the arts can impart."

The Council's charge reflected its growing awareness that the arts have traditionally reached some groups more than others. The Endowment consequently asked Mrs. Phyllis Wyeth to consult with a broad spectrum of arts, arts administrators, special constituency groups and educators to determine how the Endowment might make the arts more available to handicapped people. Mrs. Wyeth's report was submitted to the Council in August 1975.

Subsequently, in 1976, the Endowment, with the concurrence of the National Council, created the position of Coordinator for Special Constituencies to serve as a full-time advocate for handicapped, older Americans, and institutionalized populations.

The Endowment advocates and supports arts actvities that include older people. With the State arts agencies, it continues to be a primary sponsor of quality arts programs for the elderly. The Endowment encourages ways to open quality arts programs to the elderly; it does not encourage special programing for the elderly.

Older people communicate through the arts with other generations and contribute to the vitality of the arts in the community. They are also currently involved in many arts programs around the country. They are artists, instructors, students, volunteers, and consumers.

But, regrettably, attitudinal, financial logistical, and architectural barriers continue to hamper efforts to provide creative experiences for older adults. We are, however, making progress. More arts organizations are addresing these problems through ticket subsidies, innovative design, research, and media, and outreach projects.

Each year, we see greater sensitivity to how the arts relate to older people. More arts organizations now realize the value of developing older adults as audiences. But many administrators in the field of aging do not yet understand how the arts stimulate mental growth, foster self-confidence, and provide opportunities for intergenerational learning. The partnership that the Endowment has initiated is thus still quite fragile.

OFFICE FOR SPECIAL CONSTITUENCIES

The coordinator of the Office for Special Constituencies and her staff work within the Endowment, with other Federal agencies and with State/community arts organizations, to educate and advocate quality arts programing for older adult, handicapped, and institutionalized populations. The efforts of this office have included: (1) Technical assistance to indviduals and organizations needing assistance in developing accessible arts program; (2) cooperative projects with other Federal agencies to educate administrators and professionals about the value of arts programing to special constituencies; (3) support for addressing the needs of special constituencies through the Endowment and other arts programs; (4) technical assistance to Endowment grantees regarding compliance with Federal regulations that concern special constituencies; and (5) support for model projects which demonstrate innovative ways to make programs available to special constituencies.

The Special Constituencies Office has previously received a small program budget ($472,300 in fiscal year 1981) to support model projects, cooperative agreements with other Federal agencies, and expanded technical assistance for Endowment grantees. Because the Endowment is presently operating on a greatly reduced budget, it is necessary to reduce these moneys during fiscal year 1982. However, this office has historically been able to accomplish a great deal with a small amount of money.

INTERAGENCY AGREEMENTS

The coordinator has developed cooperative agreements with other Federal agencies to educate administrators and professionals about the value of professional arts programing to their constituencies. Most of these agreements result in more quality arts programs for special constituencies (these are supported by other agencies and the private sector) and the creation of more jobs for artists. This effort demonstrates how a small amount of money can have significant and far-reaching results. As with the model projects, the agreements are developed in cooperation with the appropriate Endowment staff and panel.

At the present time, the Office for Special Constituencies has agreements with seven other Federal agencies. Our agreement with the Administration on Aging, White House Conference on Aging (WHCoA), and National Endowment for the Humanities was developed by the Endowment to help plan cooperation in development of the arts, humanities, and aging fields, and to assure that cultural activities were on the agenda for the 1981 WHCoA. Arts were subsumed by other concerns at the three previous Conferences on Aging.

Symposium on the Arts, the Humanities, and the Older American

The centerpiece of this agreement was a policy symposium on the Arts, the Humanities, and the older American which was held February 1-3, in Philadelphia. Convened by the National Council on Aging's Arts and Humanities Centers, the symposium also became an official miniconference in preparation for the WHCoA.

This working conference brought together 80 artists, humanities scholars, and specialists on aging, to draft a proposed agenda for the 1980's in the fields of the arts, the humanities, and the aging. The symposium clearly called on public and private agencies on the aging to recognize how the arts enrich the lives of older Americans and to assign a high priority to bringing the arts to older adults.

MODEL PROJECTS

To increase arts community awareness of possibilities for accommodating special constituencies in their activities, the Office for Special Constituencies supports model projects through other Endowment programs.

The model projects are having an important impact. For example, the Buffalo Philharmonic—as the result of a grant through the Endowment's music program to research and test cordless amplification systems—is making it possible for people with a severe hearing impairment to hear and enjoy the performing arts, some for the first time. The project was developed in consultation with the University of Buffalo's audiology department and St. Mary's School for the Deaf. Twenty-five severely hearing-impaired older people worked with the symphony to test the equipment. In addition, a private organization, Onota, has given the Philharmonic a special van (the "hear mobile") that enables the orchestra to transport the amplification system to community and out-of-town concerts.

Over 200 performing arts organizations have contacted the Buffalo Philharmonic concerning the project, and a number of symphonies have purchased systems as a result. In addition, interested organizations will receive copies of the final report that includes detailed information and a handbook on recommended amplification systems.

State and Local Partnerships in the Arts, Humanities, and Aging Fields

Guidelines for the most recent group of model projects were a direct result of recommendations from the arts, the humanities, and older American symposium. The State arts agencies developed their projects in conjunction with the State humanities and aging offices. Following panel review, the National Council for the Arts recommended for approval in November 1981, 10 projects totaling $80,000. These projects include:

A grant to the Oregon Arts Council to produce a series of videotaped spot announcements that will highlight artists working with older people. Emphasis will be on the elders' real and potential cultural contributions in their communities.

The California Arts Council's Project will make cultural programs more available to seniors in the Los Angeles area. Working with the "Grand People's Company," a senior arts and humanities coordinator and docent advisers will plan programs, provide preprogram seminars, logistical support, and other services for older adults.

In order to inform and assist New York City's large elderly population, the New York Council on the Arts is working with the Brookdale Center on Aging of Hunter College to publish an Elder Arts Exchange Newsletter. This publication will be disseminated to over a million elderly persons in New York City, Rockland, Westchester, Nassau, and Suffolk counties.

The Vermont Council on the Arts is developing a museum exposure and historical research program that will provide older Vermont citizens with experiences in all phases of museum operation and exhibit interpretation. The museum outreach program will access schools, senior centers, and nursing homes.

Special Visual Arts Exhibition/WHCoA

The Endowment also sponsored the WHCoA "Patina" exhibition of works by five older artists (November 30 to December 4, 1981). The Chairman of the National Endowment attended the opening ceremonies, stating, "Although there have been three previous White House Conferences on Aging, this is the first time that the arts have been addressed and highlighted in such a manner. This should prove to be a significant step in calling to public awareness the long-term contributions of artists, as well as the value of the arts, in enriching the lives of older adults." Three of the exhibiting artists attended the opening, including Jacob Lawrence, a member of the National Council on the Arts.

ENDOWMENT'S PROPOSED AGE DISCRIMINATION REGULATION

On October 2, 1979, the Endowment became the second Federal agency, following HEW, to publish proposed regulations prohibiting discrimination on the basis of age, as required by the Age Discrimination Act. The final regulations currently remain under review by HHS and the Office of Management and Budget.

PROGRAM ACCESSIBILITY

Although the majority of older adults are not disabled, many have physical impairments which may impede their ability to hear, see, or move about with ease.

The Endowment's 504 regulations, which mandate nondiscrimination regarding people with disabilities and related technical assistance, are improving access to cultural programs for older people with disabilities. As a result of model projects, 504 seminars and technical assistance provided to State arts agencies and other Endowment grantees, arts organizations throughout the country are taking steps to make their programs more accessible to handicapped people. In the process, they are also achieving larger audiences for the arts.

ENDOWMENT FUNDING

The Endowment has certainly made progress through expanded advocacy and funding for activities involving older people. It is difficult to estimate the total number of Endowment-supported programs that serve older Americans, since people of all ages benefit from Endowment grants. The Endowment has, however, provided funding for a number of programs that primarily reach older adults. In fiscal year 1981, 134 grants in the amount of $1,599,973 were awarded for arts projects that specifically address older persons. Examples include:

Literature

COMPAS, in St. Paul, Minn., will support a long-term residency program for a consortium of three sites serving senior citizens. Activities will include 1 hour workshops on a weekly basis, readings by seniors and professional writers, and an edited publication of seniors' writings.

Hamilton College in New York will help support a program of residencies and workshops by poets, fiction writers, and playwrights. Nursing home residents will participate in the construction of the oral history of the region.

Religious Communities for the Arts in New York will develop a pilot program for a series profiling older Americans who are still actively involved in careers or have sought new life styles upon retirement.

Museums

The Baltimore Museum of Art in Maryland will expand its older adult program which includes an art history minicourse for the elderly, extensive museum tours and alternatives for the visually impaired.

Everson Museum of Art, located in Syracuse, N.Y., will develop a senior citizen outreach program, including a "behind the scenes" museum program, workshops in clay, printmaking and drawing, and lectures on art-related topics. The program was planned in cooperation with the Metropolitan Commission on Aging.

Music

Birmingham Symphony Association in Alabama will provide concerts throughout the State, designed for elderly and minority audiences.

Dinosaur Annex Music Ensemble in Massachusetts will provide community outreach activities to homes for the elderly, public libraries, and schools.

Inter-Arts

The National Council on Aging of Washington, D.C., is the only private nonprofit national resource working solely to deepen and expand older Americans' participation in the arts. They will publish a quarterly periodical that addresses arts/aging issues, exemplary programs, funding options, and general technical assistance information.

Visual Arts

San Francisco Camerawork of California will sponsor a lecture series including presentations by local photographers of new work in progress. Included in this exhibition will be older artists, Henry Wessel and Jack Walpott.

The Art Institute of Chicago School in Illinois is planning to produce and circulate extensive videotape holdings of the video data bank. The "On Art/Artists" series features in-depth interviews and profiles on artists who are mostly older adults.

Expansion Arts

Abington Art Center of Jenkintown, Pa., will provide a series of workshops in visual arts and crafts, taught by professional artists. The series will be presented to a broad constituency, including older Americans.

The American Institute for Cultural Development of San Francisco will sponsor professional artists to present lecture/demonstrations in the performing arts to senior citizens' centers, schools and community centers.

Articulture, Inc., located in Massachusetts, will present a free performing arts series for senior citizens in elderly housing facilities, nursing homes, hospitals, and community centers.

The Arts Council of Winston-Salem, N.C., will support neighborhood arts groups providing workshops and performances in various art disciplines for nursing homes and schools, and will help expand the senior citizen symphony and chorale.

ARTREACH Milwaukee, in Wisconsin, will provide a comprehensive program to special constituency groups in theater, dance, music, mime, poetry, visual arts for older, institutionalized, and handicapped persons.

Ballet Folklorico de Albuquerque, in New Mexico, is touring isolated Mexican communities—offering workshops and performances in music, dance, and folk arts. This program emphasizes working with senior groups.

The Capital Children's Museum of Washington, D.C., will train a portion of their volunteers, who are senior citizens, to promote art experiences with children.

Chinatown Building and Education Foundation of Philadelphia, supports workshops in visual and performing arts—providing Chinese cultural arts programs targeted towards older adults.

The Chinese Music Ensemble of New York, sponsors performances and outreach to young and older citizens to develop a wider appreciation of Chinese music, and maintain training programs for beginning and advanced level students.

De Cordova and Dana Museum and Park of Lincoln, Mass., supports an instruction program in fine arts, crafts, and photography for the elderly at senior citizens' centers.

The Fine Arts Council of Florida, supports locally based artists-in-residence and multiethnic outreach programs for seniors and other constituencies.

Germantown Theatre Guild in Philadelphia, sponsors theater puppet workshops, providing art experiences that bring older and younger people together.

Horizon Concerts, Inc., of New York, presents professional concerts, lectures, and demonstrations for seniors and other special constituencies. The format stresses educational values and cross-generational exchange.

The Iowa Arts Council in Des Moines, continues to present the "arts and older Americans" program—a senior citizen participatory art program which includes classes, workshops, and artist-in-residence programs.

Lomax-Hanson Junior College of Greenville, Ala., offers instruction in drama, visual arts, music, and creative writing for seniors and youth.

Lowndes-Valdosta Arts Commission, Inc., in Georgia, supports concert preparatory and followup workshops for older adults, in addition to concerts.

Pittsfield Council on Aging in Massachusetts, supports the Berkshire Artisans Gallery workshops with outreach programs to the elderly. Intergenerational art classes are emphasized.

Community Arts Service in Hawaii, offers performances entitled "Generation" by an intergenerational performance group.

The College of Santa Fe in New Mexico, has a mobile theatre company which offers theater and music to seniors in remote villages throughout the State.

Creede Repertory Theatre Inc. in Colorado, offers guest-artist residencies and readings/workshops for seniors and youth.

Folk Arts

Centrum of Port Townsend, Wash., sponsors a weeklong fiddle players reunion, joining 15 to 20 senior traditional master instrumentalists, representing a multitude of regions and musical styles.

Mexican-American Opportunity Foundation in California, assists with touring expenses for a traditional senior citizens' mariachi band to perform throughout the State of California.

Rhode Island Black Heritage Society in Providence, will support a weeklong demonstration of quilting by seven Afro-American senior citizens.

Fifteen apprenticeships are granted to seniors throughout the country.

KUAC–FM, University of Alaska, will produce 13 half-hour radio programs of stories told by elderly Alaskans, in the language of Inupiaq and English, enhanced with appropriate sound and music.

Portable Channel, Inc., of Rochester, N.Y., will support a film of traditional Mohawk legends as told by elder members of the tribe, with English translation.

The Board of Community Services to Senior Citizens, Inc., in Puerto Rico will support two instructor/organizers for a yearlong series of classes and performances of traditional Puerto Rican music and dance.

State Programs

The Iowa Arts Council supports a networking arts program designed to service elderly people. This is a cooperative between the Council, the Iowa Board of Humanities, and the Iowa Commission on Aging.

The Kansas Arts Commission supports an exhibition in six communities entitled "Images of Aging," featuring writings and drawings developed during interviews with nursing home residents.

The Montana Arts Council, in cooperation with the Montana Committee for the Humanities and the State office on aging, will establish artist-residencies in senior centers and communities.

The Arkansas Arts Council will develop a model project to provide opportunities for creative older adults to work as community resources in developing arts and humanities programs in senior centers, nursing homes, and other sites.

The Minnesota State Arts Board will form a task force and carry out an 18-month project to plan, design, and implement activities which further the involvement of elderly residents in the arts and humanities.

The North Dakota Council on the Arts will develop a statewide arts and humanities exhibition entitled "Winter Wheat," featuring art work by older Americans and interpretations of the work by older humanities and artists.

Resolution Passed by the 1981 White House Conference on Aging Committee on Conditions for Continuing Community Participation

Whereas the rights of older Americans to opportunities in the arts and humanities, education and recreational activities are coequal with their physical and economic rights; and

Whereas in order to improve access and quality to cultural, educational, and recreational services, they should be integrated into the social service and educational networks: Therefore be it

Resolved, That the Older Americans Act be amended to include "cultural services" by and for older Americans within the meaning of "social services" and "community services".

All Government agencies and private institutions receiving public funds and involved in the arts and humanities enforce the Age Discrimination Act and Age Discrimination in Employment Act.

Federal programs be directed by the Office of Statistical Policy of the Department of Commerce to research and collect data by specific age categories in regard to education and cultural matters relevant to the needs and interests of older learners, scholars, and artists.

Skills and talents of older Americans be utilized to provide cultural, educational, vocational, and recreational services and activities.

Cultural and educational needs of older Americans be more fully met, especially through the community school programs of the Elementary and Secondary Education Act.

The miniconference (symposium) report on the Arts and Humanities was accepted for informational purposes by this committee and was discussed.

Report of the Policy Symposium on the Arts, the Humanities, and Older Americans, February 1–3, 1981, Philadelphia, Pa.

SUMMARY OF RECOMMENDATIONS

I. Older Americans' roles in and access to the arts and humanities.
I.1 Multiple levels of involvement of older people in cultural programs.
I.2 Promote intergenerational exchanges of culture and values.
I.3 Broaden recognition of older creators in arts and humanities.
I.4 Special needs of handicapped older Americans.
II. Developing linkages and expanding networks.
II.1 Governmental linkages of arts, humanities, and aging activities.
II.2 Promotion of arts and humanities by social service agencies.
II.3 Involving labor and business in the arts, the humanities, and aging.
II.4 Linking humanities, arts, and aging in institutions of higher education.
II.5 Religious groups and the arts, the humanities, and older persons.
II.6 Linking the medical fields, the arts, the humanities, and older persons.
II.7 Professional associations in arts and humanities to take cognizance of aging issues.
III. Issues relating to society as a whole.
III.1 Expand cultural programing on radio and TV for older people.
III.2 Role of media in combating negative attitudes toward aging.
III.3 A need for cross-cultural perspectives.
IV. Legislation and governmental activities.
IV.1 Amendments to the Older Americans Act.
IV.2 Education legislation.
IV.3 Enforcement of age discrimination legislation.
IV.4 New emphases in Federal programs.
V. Research concerns and needs.
V.1 Research priorities.
V.2 Resource center for the collection and dissemination of information.
V.3 Use of the humanities in public policy research.
VI. Funding support.
VI.1 New patterns of support required.
VI.2 Higher priority for funding cultural needs of older persons.
VI.3 Various funding needs.

Introduction

On February 1–3, 1981, the National Council on the Aging (NCOA) convened a policy symposium on the arts, the humanities, and older Americans to make policy recommendations concerning ways that the arts and humanities give meaning and importance to the lives of our Nation's elders and that they, in turn, contribute to the cultural life of the country. Held in Philadelphia, the symposium was sponsored by the National Endowment for the Humanities, and the National Endowment for the Arts, and was an officially sanctioned miniconference for the 1981 White House Conference on Aging.

The symposium directly evolved from two developments: (1) NCOA's longstanding involvement in arts and humanities activities for and by older people and its advocacy for increased recognition of older Americans' role in the Nation's cultural life; and (2) a memorandum of understanding among the National Endowment for the Arts, the National Endowment for the Humanities, the Administration on Aging, and the White House Conference on Aging, signed on September 16, 1980. This interagency agreement outlined long-range plans for cooperation in the areas of the arts, humanities, and aging of which the symposium was a key initiative.

The symposium had a threefold purpose: (1) To deliberate issues and make recommendations for consideration at the 1981 White House Conference on Aging; (2) to build a broad foundation and framework for mutually supportive working relationships among humanities scholars, artists, and people in the field of aging; (3) to develop, through the publication of a volume gathering the products and conclusions of the symposium, a future agenda for the arts and the humanities as they relate to older people and to aging.

A 10-member steering committee was created to oversee and help plan the symposium. The following artists, humanities scholars, and specialists in aging comprised the committee's membership: W. Andrew Achenbaum, historian, Carnegie-Mellon University; Lew Ayres, actor and lecturer, representative of the Screen Actors Guild; Willard L. Boyd, president, University of Iowa, and member, National Council on the Arts; Dr. Robert N. Butler, director, National Institute on Aging, and honorary chair of the symposium steering committee; Selma Burke, sculptor, New Hope, Pa.; Ronald Gottesman, director, Center for the Humanities, University of Southern California; Nancy Hanks, member, White House Conference on Aging Advisory Committee, Washington, D.C.; Harry R. Moody, philosopher and director of academic affairs, Brookdale Center on Aging, Hunter College; Billy Taylor, jazz musician and composer, New York; and Carolyn E. Setlow, vice president, director of corporate planning Newsweek, Inc., and chair of the symposium steering committee.

In preparation for the symposium, NCOA, through its National Center on Arts and the Aging and senior center humanities program, called upon key leaders of arts and humanities programs to convene community forums addressing the creative, cultural, and intellectual needs of older Americans. The response was immediate and enthusiastic. Working with an outline of suggested discussion topics, groups organized forums in senior centers, congregate meal sites, libraries, nursing homes, senior housing complexes, and community colleges.

The reports and recommendations received from 57 different locations representing 21 States and the District of Columbia were synthesized and distributed to symposium participants for consideration in their deliberations. A total of 3,112 persons took part in the forums from July through December 1980, the majority being older adults, but also including professionals in the aging field, university faculty, arts council members, and State and local officials. What emerged from the forums was a vivid picture of the creative energy of countless older Americans and very strong testimony indicating that issues of life enrichment are of significant concern to them.

In further preparation for the symposium, seven background papers were commissioned to help establish a direction, authority and framework for conferees' deliberations. The subjects covered were: "Aging and Cultural Policy"; "The Arts and Older Americans: A Progress Report"; "The Humanities and Aging America"; "Older Americans and the Arts: Analysis of Current Survey Findings"; "Report on Arts and Humanities Community Forums"; "Japanese Arts and the Aging: A Living Tradition"; and "Arts and Minorities."

Eighty-two artists, humanities scholars, specialists in aging, and older persons involved in arts and humanities programs attended the symposium at the invitation of NCOA acting on the advice of the symposium steering committee. Originating from 25 States and the District of Columbia, participants represented diverse backgrounds, interests, and groups. They were divided into small working groups, each with a facilitator and rapporteur, and intermittently shared collective findings and recommendations at regularly scheduled plenary sessions. On the final day of the symposium they reviewed a published collection of issues and recommendations emanating from all groups, refined them, identified gaps, and then prioritized recommendations.

The overwhelming sense of the symposium was that the arts and humanities contribute as much to the vitality and well-being of the Nation and its citizens, including older Americans, as other activities often deemed more essential to physical survival. The following preamble, drafted by symposium participants, states the assumptions and goals underlying present and future policies for the arts, the humanities, and aging.

Preamble to Symposium Recommendations

The arts and humanities, repositories of our cultural heritage, offer perspectives, traditions, and esthetic achievements in which elders, like all others, can find opportunities for expression and for learning. The creation, understanding, and transmission of art and knowledge make life more than a matter of physical survival—more, in Yeats' words, than a "long preparation for something that never happens." The arts and the humanities enrich lives; they can be pursued in solitude and in company; they are common to peoples of all ages, sexes, races, and creeds.

Therefore, the rights of older Americans to opportunities in the arts and humanities are coequal with their rights to be well-fed, well-housed, and well-defended. Extending life without extending meaning to people's later years can be a cruel hoax. It must be national policy to recognize and support the rights of older people to discover fulfillment through the arts and humanities and to insure that they, no less than other age groups, be provided with opportunities for sharing, both as givers and receivers, the heritage they helped create and sustain in their younger years. Creation, expression, and learning must be seen as the functional equivalent of work.

The United States has for too long ignored the cultural needs and perspectives of its older citizens. The consequence is impoverishment of the lives of older people, whose creative potential remains unfulfilled, and of younger persons, whose knowledge of themselves and of others requires the memory and experiences of their elders.

To insure that the ideals in this preamble are realized, the following recommendations and policies should be adopted by the delegates to the White House Conference on Aging and by all public and private agencies involved in the arts, the humanities, and aging.

I. Older Americans' roles in and access to the arts and humanities

No previous generation of older Americans has lived through such extensive socioeconomic changes resulting from major wars, technological innovations, new patterns of work and leisure, and population mobility. The elders of today constitute a unique link between rural, preelectric society, and the "post-industrial" society. Regrettably, neither society nor even many older people recognize the significance of their experience and perspectives. This is a reflection and result of negative images of aging, affecting society in general and older persons in particular. Involvement in and access to the arts and humanities by today's and tomorrow's older Americans, both the impaired and the well, can help them make retirement a domain of meaning rather than an empty time and space and can also help them validate, explore, and transmit the richness of a lifetime's experience as a link between the past, present, and future.

Recommendations

I.1 *Multiple levels of involvement of older people in cultural programs*

All programs in the arts and the humanities for older people should provide, to the fullest extent, opportunities for them to exercise their talents and interests as professional artists, trained amateurs, students, scholars, consumers, public interpreters, advisers, and leaders.

Several possible action steps seem desirable:

Include in funding, stipulations to community organizations and programs, the requirement that qualified older people, including older artists and humanities scholars, be actively sought and adequately utilized in the direction and implementation of all cultural programs and projects.

Arts and humanities institutions and agencies, such as the State arts councils and humanities committees, should involve older individuals in advisory and policy-making roles to every extent possible.

Aging and cultural organizations at the local, State, and national levels should establish and maintain "talent banks" for use in tapping the creative resources of older artists and humanities scholars.

The arts, humanities, and aging networks should develop and expand ways of addressing the needs and potential contributions of older Americans who have been denied full access to the arts and humanities in their younger years.

Develop additional projects which demonstrate to more older people how engagement in the arts and humanities can contribute to their lives.

I.2 *Promote intergenerational exchanges of culture and values*

Agencies, programs, and communities should promote and develop opportunities for people of all ages to meet and exchange cultural traditions, creative visions, and skills.

Possible courses of action include:

State arts councils and humanities committees should encourage the creation of individual or group apprenticeships to pair experienced older craftspeople with motivated youth in folk and decorative arts, and other aspects of our diverse cultural heritage.

School systems should explore ways for older people to facilitate the transmission of cultural values and artistic talents to school-age children.

Encourage and support oral histories and autobiographical writings of older people in letters and in the fine and performing arts for transmssion to younger generations.

I.3 *Broaden recognition of older creators in arts and humanities*

The media, cultural and educational institutions, communities and society at large should honor in symbolic ways the accomplishments of older creators in the arts and humanities as a step to correct "ageism."

Actions such as the following will advance this recommendation:

Annual televised awards to distinguished older Americans who have made outstanding contirbutions to the Nation's cultural life.

Creation and showng of films and filmstrips depicting the lives and contributions of older people in the arts and humanities.

Cultural and social service agencies in local communities should provide adequate facilities and opportunities for older creators in the arts and humanities to display, perform, or publish their works.

I.4 *Special needs of handicapped older Americans*

All arts and humanities programs, projects, and events should provide greater access for impaired older persons.

The following action steps are suggested:

Develop more model projects in aging which demonstrate the letter and spirit of the law stated in section 504 of the Rehabilitation Act of 1973.

Involve physically handicapped older adults in planning arts and humanities programs for special audiences.

Develop training workshops and other materials to help cultural service providers learn about a multiplicity of handicaps and develop programs to accommodate them.

Encourage friendly visiting and visiting nurses programs to include specially designed arts and humanities projects in their services to the homebound elderly.

II. Developing linkages and expanding networks

The multifaceted conceptual and programmatic connections among the arts, the humanities, and aging need to be strengthened and made more mutually reinforcing. This can be accomplished by insuring that groups, institutions, and segments of society subscribe to the goals expressed in the preamble and by forging linkages and partnerhips across a broad range of public and private organizations.

Recommendations

II.1 *Governmental linkages of arts, humanities, and aging activities*

Local, State, and Federal Governments should establish formal links among agencies to promote the function of the arts and humanities in improvng the quality of life of older Americans.

Several possible actions emerge from this recommendation:

Implement to the fullest possible extent the recently consummated interagency agreement of cooperation among the Administration on Aging, the National Endowment for the Humanities, and the National Endowment for the Arts.

Encourage States and localities to develop cooperative agreements similar to the Federal model and to provisions included in the Older Californians Act of 1980.

Establish an office or desk in an appropriate agency to coordinate efforts and disseminate information, among all governmental bodies having direct or indirect interests in the arts, the humanities, and older people.

II.2 *Promotion of arts and humanities by social service agencies*

Social service agencies, particularly those serving elders, should integrate and make paramount the role of the arts and humanities in improving the quality of life of older Americans and should actively involve professional artists and humanities scholars in the creation and operation of programs.

Among other possibilities the following action steps are recommended:

Extend more widely artist and humanist-in-residence programs at senior centers, nursing homes, or other facilities serving the needs of older people.

Establish regular channels for liaison and cooperation among State arts and humanities councils, and area agencies on aging, and State offices on aging.

Offer aging service providers greater exposure to and training in arts and humanities programing either through demonstration sessions at appropriate meetings of State, regional, and national associations in aging (e.g., National Association of State Units on Aging) or through specially convened training sessions at the local level.

II.3 *Involving labor and business in the arts, the humanities, and aging*

Labor unions, businesses, and industries, many of whom have supported various aspects of the arts and humanities, should devote more attention and resources to supporting the endeavors of older people in these fields.

Labor and business can begin to implement this recommendation with several action steps:

Recognize and utilize the contributions that the arts and humanities, especially through the services of retired or older Americans, can make to their ongoing purposes and activities.

Hire older artists and humanities scholars to design specific life-enriching experiences as part of regular retirement preparation programs.

Introduce arts and humanities programs and discussions directly into work situations or environments as a preparation for enriching people's life after work.

Actively develop partnerships with local arts, humanities, and aging agencies to seek new ways to involve older citizens in the cultural and intellectual life of their communities.

II.4 *Linking humanities, arts, and aging in institutions of higher education*

Institutions of higher education should integrate topics and perspectives of the arts and the humanities into gerontology programs and should also examine their services and curricula in the arts and humanities with a view to making them more accessible to older people of all backgrounds.

To carry out this recommendation, postsecondary education institutions should:

Utilize retired faculty in the arts and humanities to develop courses on and off campus for older adults.

Endow chairs in the arts and humanities for retired professors to recognize their achievements and to encourage them to work with their peers.

Require students in gerontology to take at least one course in the arts or humanities as specifically relate to aging.

II.5 *Religious groups and the arts, the humanities, and older persons*

Religious bodies, individual congregations, as well as associations, must recognize the importance of older people's creativity and intellectual prowess to the life of their organizations and seek new ways to promote cultural contributions and activities of elders.

The following actions are suggested:

Encourage religious groups to return to historical precedents of commissioning and displaying works by older member artists and humanists in the group's facility.

Involve older members in planning arts and humanities programs for the congregation as well as the community.

II.6 *Linking the medical fields, the arts, the humanities, and older persons*

Arts and humanities networks should establish formal and informal relationships with medical, mental health, and therapy agencies and organizations to promote better understanding of how the arts and the humanities can enrich health care in old age.

Several actions can be taken:

Include representatives from medical disciplines in demonstrations, workshops, and seminars dealing with arts and the humanities as vehicles for communication among and socialization of older persons.

Encourage use of older artists and humanists as advisers to health care agencies and organizations serving older adults. Promote inclusion of arts and humanities subject matter into scientific curricula used in training health care and medical personnel.

Expose administrative and nursing staff of institutions housing vulnerable older persons to arts and humanities programs specifically designed for these populations.

II.7 *Professional associations in arts and humanities to take cognizance of aging issues*

Professional associations in the arts and humanities on local, State, and national levels should take greater cognizance of aging issues and when planning activities should consider the interests of older artists and humanities scholars as well as those of the older Americans in general.

By taking the following possible actions, professional associations can comply with this recommendation:

Promote the elimination of negative stereotypes of the aging in school and college curricular materials.

Encourage greater attention to aging and the concerns of older association members at conferences.

Encourage use of older artists and humanities scholars as resources in schools and colleges.

Champion increased involvement of the elderly in academic and cultural institutions.

III. Issues relating to society as a whole

The arts and humanities enrich our society in many ways, including: Creating understanding among diverse social, ethnic, racial, and religious groups; combating negative attitudes and images about older people; and communicating visions of human values and creativity to society at large. Contemporary technology can help the arts and humanities serve some of these purposes, as can older people who can function as agents for cross-cultural understanding.

Recommendations

III.1 *Expand cultural programing on radio and television for older people*

Because many older Americans, particularly those living in isolated circumstances by virtue of location or ill-health, depend on radio and television to provide the major and sometimes the only access to the arts and humanities, broadcast media should focus more on the cultural needs and interests of their older audiences.

Several courses of action are possible and desirable:

In areas where cable franchises are to be awarded, franchisers should require cable operators to: (1) Dedicate specific cable channels to programing of, by, and for older Americans and provide the necessary financial and technical support for such programing produced locally; (2) provide regular programing that promotes active participation in and information about the arts and the humanities; and (3) maintain vigilance to insure that programing portrays accurate images of older people.

In areas where cable television now exists, public agencies and private organizations should exert pressure to insure that the cable system delivers programing and information, particularly of a cultural nature, that reflects the interests of older Americans.

The Federal Government should continue and increase funding of public radio and television to insure maximum access of all people, but particularly elders, to cultural programing and activities.

Public and commercial telecommunication companies should pursue technological advances and develop programing formats that will actively engage homebound and institutionalized elders in arts and humanities activities.

III.2 *Role of media in combating negative attitudes toward aging*

Since radio and television play a decisive role in shaping attitudes toward older Americans, they should be portrayed realistically and fairly.

Among many possible actions to deal with this issue, two are particularly relevant to the arts and the humanities:

Commercial and public broadcast media should employ more older actors, especially to take older character roles.

Radio and television producers should develop programs about past and present older Americans in the arts and letters as a means of emphasizing the creative potential of older people.

III.3 *A need for cross-cultural perspectives*

Arts and humanities programs that are multiethnic in orientation, involve elders with different ethnic and cultural traditions and utilize works and creations from their diverse heritages should receive high priority.

Possible courses of action include:

Funding sources should insure that cultural programs for and by older Americans appeal to a broad mix of ethnic and racial groups and fully draw upon their creative visions and accomplishments.

American Indian elders should be utilized more fully as a resource in educating the young as well as the non-Indian population.

IV. Legislation and governmental activities

Changes in legislation, policies, and regulations of governments and institutions underlie many symposium recommendations. The symposium recommends several legislative amendments, strategies for implementing or funding present legislation, and proposals for various initiatives by the executive branch. Although the recommendations in this section relate to the Federal Government or national legislation, they are, for the most part, equally applicable to circumstances at State and local levels.

Recommendations

IV.1 *Amendments to the Older Americans Act*

When the Older Americans Act is reauthorized, Congress should make amendments insuring that the arts and humanities are specifically recognized at all possible and appropriate places in the legislation.

This recommendation calls for several specific actions:

Include under title III (State and community programs in aging) the term "cultural services" within the meaning of "social services," thereby making arts and humanities programs central to improving the quality of life for older Americans and eligible for funding.

Include under title IV–A (training) provisions to sensitize and train service providers about the intellectual and cultural needs of older persons.

Include in title V (community service employment) the term "cultural services," within the meaning of "community services," in order to increase the use of this title for the training and employment of older artists and humanists, or of other older people, in cultural services.

Add a separate authority to title IV–C (discretionary projects and programs) to permit funding of demonstration projects in the arts and humanities.

IV.2 *Education legislation*

Existing pieces of education legislation should either be funded or amended so that the cultural needs of older Americans can be more fully met.

Two possible actions are appropriate:

Fully fund title I of the Higher Education Act in order that older adults, especially those inadequately served by educational and cultural institutions may benefit from contact with the arts and the humanities.

Include greater focus on arts and humanities services by and for older persons in the community schools program of the Elementary and Secondary Education Act.

IV.3 *Enforcement of age discrimination legislation*

All Government agencies and private institutions receiving public funds and involved in the arts and humanities should enforce both the letter and the spirit of the Age Discrimination Act and the Age Discrimination in Employment Act.

Among possible action steps are:

Schools, libraries, colleges, museums, and other cultural institutions should insure that sufficient and appropriate cultural programing is provided for older adults.

These agencies should also engage older humanists and artists as employees or volunteers to an appropriate degree in their activities.

IV.4 *New emphases in Federal programs*

Federal programs stimulating research or guiding the collection of data in regard to education and cultural matters should insure that the interests of older Americans are fully met.

Several possible courses of action are necessary:

Encourage the Fund for the Improvement of Post Secondary Education to support more studies relevant to the needs of older learners, humanities scholars, and artists.

Urge the National Institute of Education to begin focusing attention on older people.

Require the Office of Statistical Policy, Department of Commerce, to instruct Federal departments and agencies, especially those relating to cultural affairs, to collect and record data by specific age categories beyond 45.

Establish a senior staff position within the Secretary of Education's office to coordinate and promote programs relevant to the cultural and educational needs of older Americans and to the nontraditional providers of such.

V. Research concerns and needs

The value of the arts and humanities to the lives of older people and their contributions to the cultural vitality of the Nation are commonly appreciated but seldom understood and documented through research findings. Progressive generations of older Americans are better educated, benefit from broader exposure to and participation in cultural activities during their younger years, and consequently find the arts and humanities more a part of their lives. It is, therefore, imperative for today as well as tomorrow to study the full impact of older people's involvement in the arts and humanities. Furthermore, to facilitate exchange of information and promote development of the arts, the humanities, and aging, research tools and dissemination mechanisms need to be developed or improved.

Recommendations

V.1 *Research priorities*

Individual scholars and research institutions, on their own initiative or with public and private support, should actively pursue a diverse range of theoretical and applied research projects exploring all aspects of the arts and humanities as relate to aging and older people.

Some suggested courses of action are:

Give high priority to projects which examine, correlates, and variations in creativity over the lifespan, particularly in later life; implications of different cultural definitions of creativity with reference to later life; myths and stereotypes held concerning creativity in later life; the effects of involvement in the arts and humanities on the physical and mental health of older people.

Urge the National Institute on Aging to expand its new interest in the creativity of older adults.

Encourage a variety of research methodologies, including scientific techniques as well as approaches drawn from the arts and the humanities.

V.2 *Resource center for the collection and dissemination of information*

A nonprofit organization, university, or the Government should establish a resource center to gather and disseminate information and data about the arts, humanities, and aging.

The mission of this center can include activities such as:

Develop comprehensive annotated bibliographies on the arts and humanities as relate to aging and older people.

Compile a national directory of artists and humanities scholars involved with older adults and gerontology.

Publish a periodical on the arts, humanities, and aging disseminating research findings and programmatic activities.

Convene or cosponsor workshops, seminars, and conferences on issues relating to the arts, the humanities, gerontology, and older persons.

V.3 *Use the humanities in public policy research*

The formulation of public policy relating to aging issues should take advantage of the multiple perspectives offered by the humanities.

To carry out this recommendation, the following actions, among others, are appropriate:

Call upon public officials and legislators to utilize scholars of history, ethics, philosophy, and jurisprudence to help pose and clarify issues in health care, work and leisure, social security and private pensions, lifelong learning, and other matters relevant to aging.

Encourage humanities scholars to undertake, and funding sources to support, policy-oriented research concerning culture and aging.

VI. Funding support

The arts and humanities, in common with other areas of contemporary America, confront economic difficulties related to inflation, energy costs, and diminishing resources. Although the arts and humanities often are ranked below "material" or "hard core" priorities, the predominate message of the symposium was that cultural needs and activities must be equated in value and importance with other issues facing society and older Americans. Given competing demands on limited resources, innovative approaches to funding clearly must be explored and utilized.

Recommendations

VI.1 *New patterns of support required*

In recognition of the increasing competition for static or even dwindling resources for many essential services, including the arts and the humanities, there needs to be systematic exploration and development of innovative patterns of support, including various mixes of public and private moneys and of contributions by volunteers.

To implement this recommendation, the following actions, among others, should be considered:

Urge organizations such as the Business Council for the Arts and the independent sector to study possible funding configurations and connections for the arts, the humanities, and aging.

Encourage older people at the local level to become advocates for funding arts and humanities programs.

Develop special tax incentives to stimulate the private sector to support cultural activities involving elders.

Encourage the corporate sector to include self-enrichment opportunities through the arts and the humanities in programs and services available to company retirees and soon-to-be retired employees.

VI.2 *Higher priority for funding cultural needs of older persons*

Given the importance of the arts and humanities to older people and the potential of their contribution to the arts and humanities, public and private funding sources should give greater consideration and priority to cultural programs and activities involving older persons.

This suggests action such as the following:

Individuals, voluntary and educational institutions, public agencies such as the Administration on Aging and the National Endowments for the Arts and the Humanities, or some broad coalition thereof, should conduct a campaign to convince private and public funding sources of the value and need for supporting various cultural activities for and by elders.

Continue and expand subsidies for both admission fees and transportation costs to enable older people to attend performances and exhibitions. Models for further dissemination are the voucher system and a "patron system" whereby purchasers of season tickets can also buy a seat for an older person at a reduced rate.

Support professionals in the arts and the humanities to provide assistance, when required or requested, to programs in environments such as senior centers, schools, nursing homes, libraries, and other locations in communities.

Existing public programs such as artists in schools should provide for older persons by establishing artist/humanist residences in senior centers, nursing homes, and other similar facilities serving older people.

VI.3 *Various funding needs*

Private and public funding sources should support a full range of projects and activities in the still emerging field of the arts, the humanities, and aging in order to promote and try new approaches and to stimulate the field to reach its fullest potential.

In addition to support for the many ideas and activities proposed elsewhere in this report, several needs merit special mention:

Demonstration and model projects which have the maximum potential for replication in many localities and which can be made self-sustaining or conducted with high-cost efficiency.

Arts and humanities programs addressing the needs and interests of the most culturally vulnerable ethnic minority elders.

Expanded outlets for older people to market their crafts.

ITEM 21. NATIONAL ENDOWMENT FOR THE HUMANITIES

DECEMBER 15, 1981.

DEAR MR. CHAIRMAN: I am pleased to enclose a report which summarizes major activities for or about the aging supported by the National Endowment for the Humanities in 1981.

It is my hope that you and your committee will find this summary of our activities and plans useful. Please let me know if we can be of any further help to your committee.

Sincerely,

CHANNING A. PHILLIPS,
Congressional Liaison Officer.

Enclosure.

REPORT ON ACTIVITIES AFFECTING OLDER AMERICANS IN 1981

I. INTRODUCTION

The National Endowment for the Humanities (NEH) recognizes the important contributions made by older Americans to scholarship in the humanities and to the broader society. It also recognizes that our senior citizens have a special need for the enrichment which the humanities can bring to their lives, as well as for the knowledge and perspectives which the humanities provide all citizens, young and old, as they strive to make informed personal and civic choices. To these ends, NEH encourages the elderly to use Endowment-supported products (such as print materials, museum exhibitions, radio, and television programs) and seeks increased participation of older Americans in a wide variety of NEH-supported activities, including scholarship, formal and informal educational programs, and discussions of public policy and other vital questions in communities throughout the United States.

Some of the ways in which older persons participate in the Endowment's programs are discussed in section II of this report.

In 1979, in order to insure that older Americans would have access to Endowment funds and programs, the Endowment developed and published in the Federal Register its proposed regulations under the Age Discrimination Act of 1975. As a result of this publication, comments on the proposed regulations were received and considered. During fiscal year 1982, the Endowment's Equal Opportunity Office will be preparing regulations in final form for publication in the Federal Register.

In the fall of 1980, NEH, the National Endowment for the Arts (NEA), the Administration on Aging (AOA), and the White House Conference on Aging developed a memorandum of understanding, outlining long-term, comprehensive programs of cooperation in the area of humanities, arts, and aging.

The cooperative plan (attached to this report as appendix A) resulted from regular meetings of NEH staff with staff at NEA and AOA. The Endowment also sponsored a miniconference on the use of the humanities by the elderly in February 1981, working toward the December 1981 White House Conference on Aging, and is consulting about appropriate activities in the humanities for the December conference.

II. PARTICIPATION BY OLDER AMERICANS IN NEH PROGRAMS

In carrying out its congressionally mandated mission of furthering the understanding of the humanities in the United States, NEH responds to the needs and interests of humanities scholars and institutions primarily as they are expressed in unsolicited applications for specific projects. Therefore, the agency does not usually set aside fixed sums of money for work in any discipline or for particular areas of the country or groups. As a result, there is no single program for senior citizens using funds specifically allocated for that group; nor is there a single program within the agency expressly designed to support the study of the aging process or of elderly people. Rather, both of these interests can be pursued through the full range of Endowment programs, depending on the project's goals and formats.

The Endowment welcomes applications from persons of any age. Through the regular selection process of the grant programs, NEH funds a great number of projects involving older individuals as project directors, project personnel, or consultants. One of the agency's most distinguished grantees, Dumas Malone, now nearly 90 years old, has completed his monumental six-volume biography of Thomas Jefferson. For this comprehensive history, which was begun in 1943, Malone won the Pulitzer Prize in 1975 for volume V of the series. (Endowment support began in 1970 and continued until 1981, when the final volume was prepared for publication.) Mr. Malone, in retrospect, says he looks on his long relationship with Jefferson as "an extraordinarily enriching experience—inevitably. I generally speak of it in terms of a journey I've made with Mr. Jefferson through half a century of momentous human history * * * So it's been a marvelous experience, and I can hardly think of not having had it. I mean you ask, Would I have tackled this job if I had known how bad it was? No, I probably wouldn't have. But I'd hate to think of missing this journey."[1] Mr. Malone is just one of the notable older scholars aided by the Endowment who demonstrate that age is no bar to significant achievement in the humanities.

Older Americans without scholarly training also make essential contributions to many of the Endowment's projects. For instance, projects for the creation of Native American language dictionaries and tribal histories frequently use elderly members of the tribe as consultants or informants. Another type of example, a project titled "The Historic Preservation of 'Poletown,'" made possible by a $16,000 grant to the Michigan Ethnic Heritage Center, used resources provided by the elderly. Oral histories and efforts to collect historical documents, records, and visual materials, and institutional and group histories, all activities with input from the elderly, are helping to preserve the "Poletown" area of Hamtramck and Detroit scheduled for destruction and urban renewal. The result of this effort will, of course, be of interest to the elderly. This project is one illustration which demonstrates how older Americans have served as both resources and audiences for many Endowment-funded projects in the humanities.

All of the activities supported by NEH to increase understanding and use of the humanities among the general public reach large numbers of older Americans.

Media programs.—The quality radio and television productions supported by the Endowment (e.g., "Heartland," the "Edith Wharton Series," "Life on the Mississippi," and "William Faulkner: A Life on Paper") are especially appreciated by older people, many of whom cannot or prefer not to leave their homes. NEH encourages grantees to promote the use of media productions among senior citizens and urges applicants to plan media programs with this group in mind. Specific information on media programs and any adjunct material produced is provided to all organizations working for special groups, including the elderly.

Humanities radio programing, like the 10-part series of 1-hour programs, "Historical Development of Washington, D.C." on National Public Radio, serves a wide audience, including the visually handicapped, who might have limited access to the humanities in other media. For many elderly people confronting problems such as impaired vision and reduced mobility, these Endowment-funded programs provide access to information as well as a mechanism for communicating with others.

Elderly persons are often valuable resources in media projects. A grant of $461,751 to Columbia College is supporting a comprehensive 2-year inquiry into the past, present, and future of southeast Chicago, a community of 100,000 persons, containing enclaves of most of the ethnic groups that settled in the American industrial communities over the past 100 years. The elderly are helping to provide insights into the history of the area.

Museums and historical organizations humanities projects program.—In this program, the Endowment is making an effort to reach the elderly by encouraging museums or historical organizations receiving project funding to reduce fees or open free to senior citizens on certain days.

---

[1] From an interview with Mr. Malone by Zoe Ingalls in the Chronicle of Higher Education, June 29, 1981.

Continuing education.—Making use of the media productions cited above and accompanying printed materials, many institutions of higher education, including community colleges, are offering courses for credit. Some of these courses are particularly suited to those elderly students whose mobility may be limited by health or transportation problems since the courses do not require attendance on campus. However, all provide good opportunities for continuing a lifelong education.

The Endowment's concern with continuing education has gone beyond courses tied to NEH-funded media productions. In 1979–80, the Endowment conducted a special initiative on continuing education. This initiative included seven regional workshops, each with participants from about 25 institutions, with discussions focusing on fashioning programing to meet the needs of a variety of new audiences, including the elderly. In the wake of these conferences the Endowment has funded applications in the area of continuing education. The resulting activities and courses are targted to adult audiences and are often of special interest to the elderly.

Courses by newspaper.—In 1981–82, the Endowment-supported "Courses by Newspaper" programs administered by the University of California, San Diego, continued to present nontraditional college-level courses. These courses are offered to the general public nationally through the cooperation of hundreds of participating newspapers and educational institutions. A series of newspaper articles prepared by outstanding scholars serves as the basis of a course offered at local colleges and universities for those readers desirous of earning college credit. More than 450 newspapers and 300 colleges and universities cooperate regularly to bring these courses to citizens of every State, Puerto Rico, Guam, the Virgin Islands, as well as parts of Europe, Canada, New Zealand, and the Far East.

Recent "Courses by Newspaper" have included "Death and Dying: Challenge and Change" (1979), "The Nation's Health" (Spring 1981), "Work in America" (Fall 1981), and "Food and People" (Spring 1982), subjects of considerable and special interest to older Americans.

Summer seminars.—The Endowment's summer seminars program last year included 55 participants aged over 55, 13 directors between 60 and 65; 5 between 65 and 70; and 3 over 70. The oldest director to date has been Prof. Alpheus Mason, at Princeton, who conducted a seminar on the role of the Supreme Court 2 years ago, at age 79.

Other projects supported by NEH are specifically designed either to increase understanding of the special problems and challenges facing the elderly or to provide learning experiences in the humanities for older citizens. These are detailed in section III of this report. In addition, regrants on NEH funds through the State humanities committees have supported many locally initiated and conducted projects of these kinds, some of which are described in section IV.

III. SPECIFIC NEH GRANTS SERVING THE ELDERLY

Continuing until the fall of 1983, the Endowment's grant of $500,000 to the National Council on the Aging for its senior center humanities program is involving 22.5 million older Americans in the humanities through activities held at more than 800 service centers (including senior citizen centers, nutrition sites, day care programs, and nursing homes). In addition, during 1981, the Endowment made new awards totaling over $565,199 for projects designed—as a whole or in part—to increase knowledge about aging or to provide special materials or activities for older persons and an additional $1,634,224 for projects which involve the elderly as resources. Endowment projects involving the aging might be divided into three categories: (1) Programs *about* aging and the elderly in our society and others; (2) programs *for* older Americans; and (3) programs *using* senior citizens as consultants or resource persons. Examples of such programs funded in 1981 follow:

A. Programs About Aging and the Elderly

Case Western Reserve University received a grant of $155,615 to support a 4-week humanities institute for college teachers that will explore research on aging to result in new undergraduate courses and course materials. These materials focus on a neglected phase of human experience. The new courses should also help dispel myths and negative attitudes toward the elderly by making the college population aware of myths, stereotypes, and negative attitudes embedded in their cultural heritage.

A grant of $20,000 to Donald S. Klinefelter, professor of philosophy at the University of Tennessee at Chattanooga, will help support a book that will explore in part the way in which economic and social values influence the bureaucratic arrangements designed to administer medical treatment, and in turn, the way these arrangements enhance or diminish the sense of moral responsibility and self-worth of both the dispensers and receivers of treatment. The writer will attend a seminar at Indiana University to present and discuss his studies.

A fellowship stipend of $2,500 to Charles R. Wilson, visiting assistant professor of American History at Texas Tech University, supported long-range research on Southern attitudes and customs in ragrd to death from 1830 to 1980. The research focuses on the 1865 to 1920 period, when a distinctive "Southern Way of Death" helped to preserve the "Southern Way of Life" with its identifiable political, social, racial, and religious patterns.

A book on the ethical problems involved in euthanasia is the planned result of a $20,000 grant to J. Chrisley Hackler, associated professor of philosophy at East Tennessee State University. Mr. Hackler will attend a seminar at Indiana University to further present and discuss his views.

B. Programs for Older Americans

A grant of $22,000 to Andrew Achenbau[illegible] of the Carnegia-Mellon University is supporting research for a book tentatively entitled "Social Security in Historical Perspective," which would trace social security from the germination of an idea for government assistance for the aged and aging and which would forecast developments in the short- and long-run.

This $37,515 grant to the Central Agency for Jewish Education, Miami, Fla., is supporting public programs on Hispanic and Jewish history, including discussions of music and art, and audiovisual presentations for 2,000 senior citizens of the Greater Miami area.

The Mid-Mississippi Regional Library Commission with a grant of $5,000 has planned programs of independent study and group presentations both serving and using senior citizens as resources in the development of learning packets on local history in five rural Mississippi counties.

An $88,342 grant to the University of Kansas, Laurence, is for support and evaluation of a project to bring humanities study programs to nursing home resident through closed circuit radio as well as through trained volunteer discussion sessions.

A grant of $48,747 to Chatfield College, St. Martin, Ohio, has made possible two series of 6-week minicourses for the elderly on local social and art history—one for urban Cincinnati and the other for rural Brown County, Ohio. The project is expected to serve as a model for other regions and will be publicized nationally.

A $15,000 grant to the Caroline County Public Library, Denton, Md., has supported the planning of booklets, slide shows, and programs on the folklife and social history of Caroline County's small towns. The project is expected to be of special interest to the elderly.

C. Programs Using Senior Citizens as Resources

A grant of $17,000 to the Association Nacional Pro Personal Mayores in Los Angeles, Calif., is providing for the planning and development of an oral history project focusing on Mexican, Cuban and Puerto Rican migration. Radio and print materials will be developed for public audiences.

A $13,994 grant to the Homer Society of Natural History is for a program in which youth, aged 14 to 18, will be trained to interview and photograph surviving homesteaders in the Homer/Kachemak Bay area of Alaska. Results and process of this project will be disseminated through an oral history kit, workshops, and a slide-tape for a larger youth audience.

A grant of $48,430 to the Capital Children's Museum in Washington, D.C. is for a program to train youth, ages 11 to 16, to gather oral histories from senior citizens examining the impact of changes in society and technology on family communication. The taped interviews will be the basis for radio programs, group presentations, and a museum exhibit on the oral tradition.

A $2,500 grant to the Pekin Public Library will support the creation of video casettes about the history of Pekin, Ill., with on-location footage, still pictures, and interviews with senior residents of the community. The library will make tapes available for loan to the public.

The Idaho State Historical Society received a grant of $99,899 for development of a statewide network of scholars and information resources (including the elderly), to assist with community history projects.

A series of community forums titled "Baltimore Voices," in which a social history performance is used to stimulate dialog on public issues, is being supported by a $155,000 grant to the Baltimore Theater Project, Inc. The elderly are important both as resources and audiences in this project.

A grant of $266,390 to Michiana Oral Labor History Project, Indiana University, Bloomington, is providing for the development of a statewide network of scholars, trade unionists, and community members for preserving Indiana's 20th century labor history. This project will include oral history workshops (in which older persons will serve as information resources), writing clinics, public meetings, intepretive exhibits, and regional labor history pamphlets.

A grant of $75,000 to the Center for Southern Folklore in Memphis, Tenn., is for a folklife festival in the Mid-South that will celebrate and interpret through the humanities the region's traditional folklife and ethnic diversity. Followup workshops will feature a humanities scholar meeting with artists in their own communities. Older persons will be valuable resources.

A $147,323 grant to the Spokane Tribe of Indians in Wellpinit, Wash., supported planning for a program to record and preserve the native language of the tribe through principal involvement of tribal members—often elderly persons.

A grant of $57,071 to the Suquamish Tribe in Suquamish, Wash., supported the collection of oral histories in order to document the transition from traditional to modern cultures. Educational materials will be produced for use by Indian organizations. Older persons were valuable resources for the project.

A grant of $35,264 to Camera News, Inc., of New York, N.Y., is for the script development for a 60-minute documentary film examining the history and experience of the Chinese in the Mississippi Delta region. Key issues are acculturation of minorities in American society and race relations among blacks, Asians, and whites. Senior citizens will be used as information resources.

IV. STATE PROGRAMS AND THE AGING

The State Programs Division of the Endowment makes grants in the 50 States and in Puerto Rico and the District of Columbia to State humanities committees. These committees, in turn, respond to competitive applications from institutions and organizations within the State for humanities projects of broad benefit to the citizens of the State. Although each State group may determine the kinds of humanities activities it wishes to support, the majority of the projects funded across the country focus on issues of public policy or of contemporary concern to the society. Therefore, many projects deal with the topics of biomedical ethics, death and dying, the status of the family within the society, and with other issues of particular concern to the elderly. Below are presented some examples of projects which are specifically directed toward the elderly or focus directly on the problems of the elderly rather than on the galaxy of related issues of health care, family, etc., mentioned above.

Examples of State Humanities Projects Directly Affecting Older Citizens

Of the approximately 200 State regrant aging projects undertaken by 36 States in 1981, the following suggest the variety of activities supported, especially those whose content and concepts might be duplicated in other communities.

Although the variety of these projects can only be suggested here, they generally include one or more of the following features: Exploration of the values and assumptions implicit in our behavior toward the elderly at present; exploration of attitudes toward aging in other cultures or in other periods of American history; programs on the topics of death and dying; and programs of personal enrichment in the humanities directed specifically to elderly audiences.

Alabama (the Committee for the Humanities in Alabama): A grant to the Wheeler Basin Regional Library supported a series of six weekly presentations at five senior citizen centers. Explorations were made into the myths and realities of the rural South. An anthology of writings about the South was available for each participant, in large print and on tape for the visually impaired.

Alaska (Alaska Humanities Forum): A grant to Anchorage Community College will make possible the recording and distribution of oral histories of approximately 100 early pioneer women. Material will be tape recorded to produce resource material for public dialog and instructional material for academic and social agencies.

Arizona (The Arizona Humanities Council) : A grant to Continuing Education—University of Arizona has supported sessions led by a scholar in history and literature that focused on the nature of and changes in the American family as they affect senior citizens' understanding of their personal and public roles.

Delaware (the Delaware Humanities Forum) : A grant to the State of Delaware's Division of Aging supported programs held in Georgetown, Dover, Wilmington, and northern New Castle. A historian outlined the development of programs and history of caring for elderly. Talks and dialog are being edited and published as a resource.

Georgia (Committee for the Humanities in Georgia) : A grant to Saint Johns Towers, a senior citizen residence, supported a project using Alistair Cooke's series "America."

Illinois (the Illinois Humanities Council) : Western Illinois University used a grant for a project entitled "Tales From Two Rivers." Manuscripts submitted by the elderly throughout western Illinois were selected, grouped, edited, introduced by the scholars in the humanities, and published in soft cover. The manuscripts are being treated as historical documents which can provide a personal and valuable perspective on the history of western Illinois since the turn of the century.

Idaho (Association for the Humanities in Idaho) : A grant to the Ida Cache Council for the Arts helped fund a centennial project which was of particular interest to the elderly. During late 1981, Preston, a small, predominantly Mormon, agricultural town in southeast Idaho celebrated its centennial year. To supplement other activities, this project included an exhibit of pen and ink drawings documenting changes in Preston's architecture, a four-part lecture series, a series of four exhibits tied to the lecture topics, and an autumn history fair involving school children in grades 4 through 12.

Kansas (Kansas Committee for the Humanities) : A grant to Wichita State University helped support six weekly film presentations followed by discussion between a panel of humanities scholars and other representatives of community aging network and the audience. The focus was on American cultural values and their relationship to the aging experience and how these are depicted in films.

Massachusetts (the Massachusetts Foundation for the Humanities and Public Policy) : A grant was awarded for a videotape documentary based on the book, "Not So Long Ago: Oral Histories of Older Bostonians." Interpretation complemented the oral histories, establishing connections between the past and current problems the elderly are facing today.

Michigan (the Michigan Council for the Humanities) : A grant to Aquinas College is supporting a series of lectures and discussions on humanities topics. Sessions include "Christian Art in the Western World," "The Theatre, Yesterday and Today," "Humanities and a Holistic View of Life," "History and Culture of the Netherlands," and many other topics, including present political and social issues. Activities were held in nursing homes, community centers, and on campus.

North Carolina (the North Carolina Humanities Committee) : A grant to High Point College supported the activities of a group of senior citizens who studied, with a team of six humanities scholars, basic cultural values which underlie the Nation, to explore how these have influenced the culture and have been shaped by the culture in America over the years.

New Mexico (the New Mexico Humanities Council) : The Columbus Historical Society sponsored humanities scholars from Western New Mexico University to accompany each of eight American short story films in Deming and Columbus, N. Mex. One-page commentaries were prepared for distribution to audiences, including older persons meeting at senior centers, to raise questions, point to dilemmas, illustrate the story's place in development of American culture and how it sheds light on periods of American past. Scholars introduced each film and led discussion after film showings.

Oregon (the Oregon Committee for the Humanities) : A grant to the Northwest Media Project is for films on Northwest history and ethnography shown at senior centers. Humanists provided interpretive commentary and led discussion on such topics as the role of minority groups in the settlemen of Oregon, the subculture that has built up around logging, and the maintenance of family ties as members grow older.

Pennsylvania (the Public Committee for the Humanities in Pennsylvania) : The goal of this project, supported by a grant to Allentown College of St. Francis de Sales, is to form a planning committee to create a program designed especially for senior citizens for increasing understanding of art, culture, philosophy, and literature of American Indians, especially tribes indigenous to the Lehigh Valley.

South Dakota (South Dakota Committee on the Humanities): A grant to Mount Marty College supported this project comprised of six week-long humanities programs for senior citizens on five South Dakota college campuses. Topics included: Indiana/Pioneers in Siouxland; Contemporary Poets/Poetry; Touch of Spanish: Language/Culture; and American Frontier: Myth/Reality. The project's purpose was to introduce older citizens to the humanities, and encourage them to participate in the world of ideas, cultural traditions and history.

Texas (the Texas Committee for the Humanities): Texas Tech University sponsored a 3-day conference on humanities and gerontology to provide a forum for exchange of ideas relating to literary and artistic concerns and the significance of the impact of humanities upon the daily lives of the elderly. Humanities will serve as the basis of discussion, and stimulate thinking of the possibilities about the quality of life for the aging. Scholars in literature, anthropology, history, religious studies, and philosophy appeared as panelists. The conference was held during the Third Annual Spring Gerontology Conference.

Washington (the Washington Commission for the Humanities): A grant is helping to support three 10-week literature discussion groups for senior citizens and 10 performances to explore the value and meaning of life as expressed in contemporary and classic literature. Weekly themes include freedom, families, maturity, solitude, roles, adversity, courage, and survival. The reading groups discuss assigned readings and write essays on themes as they relate to their past experiences. Their essays will then be developed into short plays which will be performed.

West Virginia (the Humanities Foundation of West Virginia): A grant to Glenville State College is supporting humanities programs in senior centers in a 17-county area in northern and central West Virginia. Four to ten sessions were presented in each county on history, music, literature, art, philosophy, etc.

Wyoming (the Wyoming Council for the Humanities): A grant to the University of Wyoming-School of Extended Learning supported a tour of WCH Fellow Carol Rankin's narrated slide program at senior citizen centers throughout the eastern part of Wyoming. The script, developed from oral histories from Sublette County, focuses on the changing role and attitudes of women regarding ranch life. Audience was provoked to consider changing values in their region.

Appendix A

A Collaborative Plan for the Administration on Aging, the National Endowment for the Humanities, and the National Endowment for the Arts Providing Arts, Humanities, and Aging Programs

INTRODUCTION

The arts and humanities are useful vehicles creating a measure of self-worth and esteem through self-expression and life enhancement. They can be a means to involve the older person in the community, a means to tap a resource which heretofore has been largely unnoticed. In addition, arts and humanities programs for and with older persons can produce dividends beyond that of enrichment for this large number of Americans.

The Administration on Aging, the National Endowment for the Arts, and the National Endowment for the Humanities developed an interagency agreement in September 1980, to provide for and plan for full and comprehensive programing involving the older person with the arts and humanities. The memorandum of understanding which formalizes the agencies' "agreement to agree" called for the creation of an interagency task force, the convening of a policy symposium focused on the arts, humanities, and aging, and the development of a collaborative plan for cooperative programing and information exchange. This agreement follows a decade of increasing attention to the arts, humanities, and aging by the agencies involved.

The National Endowment for the Arts encourages projects that involve older Americans as participants and audiences at all levels within the Arts Endowment and these programs are integrated into all 14 Endowment programs. The Office for Special Constituencies was established in 1976 by the National Council for the Arts as an advocate for arts programing for older adults and other constituencies. These advocacy efforts include: (1) Technical assistance to organizations concerning program development, resources, and regarding compliance with Federal regulations that concern special constituency populations; (2) advocating more support through Endowment programs, State and local arts agencies, and other Federal agencies; (3) initiating cooperative projects with other Federal agencies; and (4) providing support for model projects that demonstrate innovative ways to make programs available to special constituencies. The Endowment has served as a leader for State and local organizations through its advocacy and support of professional arts programs involving older Americans.

The National Endowment for the Humanities encourages utilization by the elderly of the Endowment's supported projects (such as print materials, museum exhibitions, radio and television programs) and seeks to increase participation of older Americans in a wide variety of Endowment support activities, including scholarship, formal and informal education programs, and discussion of public policy and other vital questions in communities throughout the United States. Specific Endowment grants serving older Americans have generally fallen into three areas: (1) Programs about aging and the older person in our society, including the introduction of courses on aging and the humanities, and museum exhibits; (2) programs for older Americans including the National Council on the Aging's senior center humanities program; and (3) programs using older Americans as consultants or resource people, including oral history projects involving native Americans, ethnic minorities, and retired labor union members.

The Administration on Aging under the authority of the Older Americans Act, as amended, administers programs designed to foster the development of comprehensive and coordinated service systems which promote the independence and reduce the need for institutionalization among the elderly. State and area agencies on aging have major responsibilities in planning and management, and serve as focal points for all matters pertaining to older persons in the State and community. Funds are awarded to State and area agencies to enable them to enter into cooperative agreements with other agencies and providers of social services to remove individual and social barriers to economic and personal independence for older persons. Under title IV of the act, the Commissioner is authorized to support manpower and training activities for personnel in the field of aging research concerned with the living conditions of the elderly and demonstrations designed to improve and extend the social services for older persons. Arts and humanities projects by the Administration on Aging date from the beginning of the human equation project continuously through current projects involving training for social service professionals with an arts and humanities emphasis by CEMREL, Inc., and Eastern Washington University's gerontological uses of history project.

INTERAGENCY AGREEMENT

In September 1980, the Administration on Aging, the 1981 White House Conference on Aging, the National Endowment for the Humanities, and the National Endowment for the Arts signed a memorandum of understanding agreeing on long-term, comprehensive programs of cooperation in the area of arts, humanities, and aging. The agreement called for the establishment of a task force to implement the agreement and to develop a plan of cooperation with strategies most suitable for collaborative programing, planning, and policy. The second major element of the agreement called for policy and program analysis in the arts, humanities, and aging by holding a policy symposium in cooperation with the 1981 White House Conference on Aging to focus on the need, demand, and character of arts and humanities programs involving older persons. The policy symposium would set the tone for the initiative and lay the groundwork for long-range, comprehensive programing for and with the older person in the arts and humanities.

POLICY SYMPOSIUM

In February 1981, the National Council on the Aging convened a Policy Symposium on the Arts, Humanities, and Older Americans to make policy recommendations concerning ways that the arts and humanities give meaning and importance to the lives of our Nation's elderly and that they, in turn, contribute to the cultural life of the country. The symposium was sponsored by the National Endowment for the Humanities and the National Endowment for the Arts and was a sanctioned miniconference for the 1981 White House Conference on Aging.

The symposium had a threefold purpose: (1) To deliberate issues and make recommendations for consideration as the 1981 White House Conference on Aging; (2) to build a broad foundation and framework for mutually supportive relationships among humanities scholars, artists, and people in the field of aging; (3) to develop through publication of a volume gathering the products of symposium, a future agenda for the arts and humanities as they relate to older people and aging.

The overwhelming sense of the symposium was that the arts and humanities contribute as much to the vitality and well-being of the Nation and its citizens, including older Americans, as other activities often deemed essential to physical survival. Thus, the recommendations stemming from the symposium concerned: (1) Older Americans' roles in access to the arts and humanities; (2) the need to develop linkages and networks among the arts, aging, and humanities; (3) the relation of the arts, humanities, and aging in general to society; (4) recommend legislative and public sector activities; (5) research concerns and needs; and (6) funding support for the arts, humanities, and aging.

TASK FORCE

The task force stipulated by the interagency agreement contributed to the planning of the policy symposium and, in addition, has reviewed the programs and policies of each agency to explore possible links for coordinated and cooperative efforts. The review examined program, research, training, and evaluation efforts. Following the recommendations of the policy symposium, the task force proceeded to identify those areas of programing most suitable for cooperation and develop proposals for collaborative interagency implementation. The intent of this collaborative plan developed by the task force, and indeed the intent of the initiative, is to make arts and humanities programs more numerous and available to the older person and increase the sensitivity of the aging field to the potential of arts and humanities programs for and with the older person. The aim is to make the arts and humanities a logical part of the continuum of services, increase the resources available for this programing by making individuals aware of programs, and facilitate communication and information exchange among the regional, State, and local counterparts of the federal partners. To this end the strategy of the collaborative plan was developed.

COLLABORATIVE PLAN

The general approach behind the plan emphasizes an affirmative supportive relationship among the Federal agencies' staff and their counterparts at the State and local level. The Federal agencies will act primarily to facilitate and support State and local agencies' efforts and provide appropriate assistance when requested. In addition, the Federal agencies will follow a policy of advocacy and dissemination to encourage State and local utilization of "best practice" models. More specifically, the collaborative plan will be based on a three-pronged strategy: Continued cooperation at the national level; network development among the State and local partners; and information dissemination and utilization. To a lesser extent, there are funding elements to the plan.

The specific recommendations include:

Continued Cooperation at the National Level

A specific policy of invitation to the other agencies for representation in the review process of major proposals before the agencies which are specifically relevant to the arts, humanities, and aging.

A specific policy of invitation to the other agencies to attend meetings of the agencies' advisory committees.

A review of ongoing projects of each agency which are relevant to the initiative and may be candidates for add-ons or for a redefinition of scope.

A specific policy of information sharing and personal meetings among the information and library professionals for each agency.

To secure a meeting of the national service organizations of the State and local partners, viz, the National Association of State Arts Agencies, the National Association of Community Arts Agencies, the National Association of State Units on Aging, the National Association of Area Agencies on Aging, and the Federation of Public Programs in the Humanities.

Information Dissemination

To amend the cooperative agreement between the Administration on Aging and CEMREL, Inc., to provide project handbooks for distribution to the arts, humanities, and aging networks.

To encourage the National Council on the Aging to distribute best practice models, program ideas, and resource materials through the Center for Arts and Aging and the Senior Center Humanities Program.

Publicize the potential of arts, aging, and the humanities through companion articles in Aging, the Cultural Post, and Humanities, as well as coordinated press and media releases by the public information departments of each agency.

Network Development

Encourage State and local agencies to develop interagency agreements similar to the Federal model. This agreement to agree would precede substantive program development. Cover letters from the heads of the Federal agencies will urge the development of cooperative relationships among the partners at the State and local levels.

Distribute to the State and local agencies information about the other agencies. This would serve to educate the three networks—aging, arts, and humanities about the existence and functions of each other, their proximity, and their potential as partners at the State and local levels.

Using regular communication processes, e.g., program memorandum, program instructions, to suggest that the arts, humanities, and aging agencies at the State and local level become involved in the annual review of State plans as part of an interagency agreement and as part of the general public involvement required of such plans.

Funding

Review existing grants of the three agencies with the explicit intention of stressing the arts, aging, and humanities portion of these activities as well as their overlap. Specific examples include:

For the Administration on Aging, the CEMREL and Eastern Washington University projects.

For the National Endowment for the Arts, the Center for Arts and Aging and the proposed projects of network development among the three fields at the State and local level.

For the National Endowment for the Humanities the senior center humanities projects and the proposed humanities-nursing home project.

These examples include two new starts: The support of a humanities-nursing home project in order to bring the humanities to a population not served by the senior center humanities project which is funded by the National Endowment for the Humanities; and, the support of a series of model projects regarding network development among the State arts, humanities, and aging agencies as demonstrations, this is funded by the National Endowment for the Arts.

SUMMARY

This collaborative plan recognizes the importance of involving older persons with the arts and humanities as well as the appropriate role for the Federal agencies involved. To this end, the collaborative plan was developed to continue the cooperation among the agencies at the national level, to develop networks among the State and local partners, and to disseminate technical assistance and information to those wishing to advocate and provide for arts, humanities, and aging programs.

ITEM 22. NATIONAL RAILROAD PASSENGER CORPORATION

DECEMBER 16, 1981.

DEAR MR. CHAIRMAN: Thank you for allowing Amtrak the opportunity to provide your committee with information to be included in your annual report, "Developments in Aging: 1981."

Amtrak recognizes that various barriers have long existed in the transportation industry which have made travel difficult, if not impossible, for some passengers. It has been Amtrak's policy, therefore, to consider the special travel needs of both the elderly and the handicapped passenger in all aspects of our passenger rail operations. From the time passengers first call Amtrak's toll-free reservations number until they complete their travel, they will be able to benefit from Amtrak's efforts to remove the barriers from intercity rail travel. A summary of Amtrak's programs to make its services more accessible and convenient for elderly and handicapped persons follows.

EQUIPMENT

In 1981, Amtrak received the last of its 284 Superliner rail passenger cars. These double-decker cars are now in service on all Amtrak's western routes. Superliner coaches and sleeping cars have been designed with special accommodations for handicapped passengers. A special coach seat or completely accessible bedroom is located on the lower level of every car for easy access. Amtrak will continue to operate its Amfleet and its new generation Amfleet II cars on its eastern routes. Each Amfleet food service car has been equipped with a conveniently located, easily accessible swivel seat with a fold-down armrest and nearby storage for one wheelchair. Additionally, all of Amtrak future equipment orders and major car refurbishments will include design specifications to insure that these passenger cars will be easily accessible.

STATION SERVICES

Amtrak is continuing to work to improve the accessibility of the 525 stations in the Amtrak system. Many of these stations are barrier-free, but some stations have barriers that may range from one curb to many flights of steps. It is Amtrak's policy that as new stations are built and old ones are renovated, they will be made accessible.

At the stations where Amtrak has station services personnel or red caps on duty, Amtrak will provide assistance upon request to enable an elderly or handicapped passenger to use all station facilities. Wheelchairs are available at almost 400 stations, and, this past year, Amtrak accepted delivery of 164 wheelchair lift devices for use at its stations with low level platforms. Additionally, Amtrak has acquired electric carriage carts that are now in service at major facilities.

SPECIAL SERVICES

Amtrak continues to maintain special services centers at all of its five major reservations sales offices. Our special services staff assists elderly and handicapped passengers in arranging for entraining and detraining assistance at all Amtrak stations as well as special meals and other on-board services for those passengers who cannot take advantage of our regular service. They maintain teletypewriters for communications with persons who have hearing disabilities. As long as Amtrak receives advance notice of the travel needs of an elderly or handicapped passenger, we can accommodate most requests.

DISCOUNT FARE PROGRAM

In 1980, Amtrak began offering a 25-percent discount on Amtrak's regular coach fare to senior citizens and handicapped passengers on all one-way trips of $40 or more. This discount fare is granted to each senior citizen 65 years of age or older who presents a driver's license, birth certificate, or other official document to establish eligibility for the discount. Cards, such as those issued by the Government, or by groups representing handicapped persons, certifying an individual as handicapped or a letter from a physician may also be used to purchase the reduced fare ticket. While this program has been successful in attracting passengers to our trains, Amtrak does plan for some modifications.

Beginning in January 1982, Amtrak's discount fare plan will allow the senior citizen and handicapped passenger who travels round trip to continue to take advantage of the 25-percent discount. The $40 minimum fare requirement will be eliminated, although, as with all discount fare programs offered, Amtrak will restrict travel on its Metroliner service trains and during certain holiday periods.

Amtrak believes that eliminating the minimum fare requirement will allow more passengers, particularly those traveling shorter distances, to take advantage of the reduced fare.

CONSUMER EDUCATION

Amtrak's current services for elderly and handicapped travelers are described in detail in a brochure entitled "Access Amtrak" which is available free of charge from Amtrak, Corporate Communications, 400 North Capitol Street, N.W., Washington, D.C. 20001.

During 1981, Amtrak has noticed a significant increase in the use of its services by elderly and handicapped individuals. As we continue to improve our services, we look forward to serving even more passengers during 1982.

Sincerely,

JAMES H. ENGLISH,
Vice President, Government Affairs.

ITEM 23. OFFICE OF CONSUMER AFFAIRS

JANUARY 25, 1982.

DEAR MR. CHAIRMAN: In response to your request, I have enclosed the "Report of Activities of the U.S. Office of Consumer Affairs During 1981 Relating to Older Americans."

My office is pleased to have the opportunity to contribute to the committee's annual report on aging. As President Reagan's Special Assistant with responsibility for liaison with the aging, I am keenly aware of the needs of the elderly. In 1982, my office will expand its activities to provide greater assistance to elderly consumers.

Sincerely,

VIRGINIA H. KNAUER,
Special Assistant to the President and
Director, U.S. Office of Consumer Affairs.

Enclosure.

REPORT OF ACTIVITIES OF THE U.S. OFFICE OF CONSUMER AFFAIRS DURING 1981 RELATING TO OLDER AMERICANS

The Director of the U.S. Office of Consumer Affairs (OCA) is Virginia H. Knauer, who is also Special Assistant to the President in the White House Office of Public Liaison, with responsibilities for consumer affairs, health care, aging, disabled, and safety concerns. Mrs. Knauer serves as the consumer advisor to the President and directs consumer affairs activity at the Federal level. OCA provides the staff and administrative support to carry out these responsibilities. The President has also designated Mrs. Knauer as the Chairperson of the Consumer Affairs Council, established by Executive Order 12160.

OCA encourages and assists in the development and implementation of programs dealing with consumer issues and concerns; advises agencies on the effectiveness of their consumer programs; exchanges views with business and industry officials by encouraging the development of voluntary employment, consumer protection and information programs; serves as the focal point for the coordination and standardization of Federal complaint handling efforts; works to improve and coordinate consumer education at the local, State, and Federal levels; and cooperates with State and local government agencies, and voluntary, consumer and community organizations in the delivery of consumer services and information materials.

The major activities focus on voluntary mechanisms, marketplace innovations, consumer education and information, and conferences to exchange information and develop dialogs. OCA activities also focus on helping State and local government units and consumer and community groups to deal with issues affecting consumers.

Highlighted below are major activities having the greatest impact on older Americans.

CONSUMER ISSUES

Banking and Credit

Cash Discount Act of 1981.—OCA presented testimony in favor of this legislation when it was originally introduced in 1980. This year OCA recommended Presidential approval after it passed Congress. The elderly benefit when merchants offer discounts for cash. The bill was signed by President Reagan July 27, 1981.

Mortgages

Adjustable rate mortgages, which allow increases, or decreases, in the interest rate and the payment in step with free market interest rate changes, have been adopted by the Federal supervisory banking agencies. These new mortgages will affect the ability of elderly citizens to buy a retirement home if they require a loan to do so. OCA continues to review and comment on the new instruments to assure that adequate consumer safeguards are included.

Regulation Z: Truth-in-Lending Act.—OCA commented on the proposed rules to implement the revisions in Regulation Z as mandated by the Depository Institutions Deregulations and Monetary Control Act of 1980. OCA comments highlighted the areas in which we believe consumers, including elderly consumers, were being placed in an unfair bargaining position.

Transportation

OCA has continued its efforts to encourage reform of laws regulating the home moving industry. Consumer abuses in the moving industry have a significant impact on the elderly, who are particularly dependent on interstate movers. The passage of the Household Goods Transportation Act (Public Law 96–456) serves to increase competition within the home moving industry, and increase consumer remedies and the Interstate Commerce Commission's ability to enforce consumer protection rules. The bill establishes guidelines for independent, informal consumer dispute resolution mechanisms. OCA, in testimony before the Senate Subcommittee on Surface Transportation, offered several suggestions regarding improvement of ICC rules with respect to implementation of the bill.

OCA is working with the National Highway Traffic Safety Administration in developing a consumer education campaign geared toward increasing consumer awareness of the importance seat belt use. The program represents an effort by the safety agency to alleviate some of the serious injuries and fatalities associated with non-use of seat belts. The campaign will focus on increasing the awareness of senior citizens.

Because of the limited income of many elderly persons, many frequently choose to purchase a less expensive used car, rather than a new automobile. OCA reviewed a Federal Trade Commission rule which seeks to reduce oral misrepresentations and failures to disclose material facts concerning the mechanical conditions of used cars and the extent of warranty coverage offered by used car dealers.

Housing

One issue of particular interest to OCA is the problem of displacement, especially that which occurs as a result of condominium conversion. There has been a marked increase in the number of conversions taking place in many city neighborhoods, and as a result many consumers, especially elderly citizens, are finding themselves in the position of being "involuntarily" pushed out. OCA will continue to work on this issue.

OCA will continue to look into the area of shared appreciation and reverse annuity mortgages, which would allow elderly citizens to remain in their residences despite the increasing costs of maintaining a home.

OCA has urged the President's Commission on Housing to allow interested persons and experts to contribute to their work. In particular, OCA recommended that organizations representing the interests of elderly citizens be invited to assist the Commission in the formulation of future housing policy.

Health Care

OCA commented on the Federal Trade Commission's eyeglasses investigation. OCA supported the staff recommendation to continue work on removing restraints imposed by State law. Removal of commercial practice restraints would decrease regulation, increase competition and increase consumer access to eyeglasses.

OCA commented on the Food and Drug Administration's proceeding regarding the partial implementation of a mandatory patient package insert program. OCA continued to support the consumer's need for readily accessible prescription drug information. This information is particularly important for elderly consumers, who purchase a proportionately greater number of drug products than the public at large.

OCA is working with other agencies and consumer groups to develop policies concerning "orphan drugs" and increased access to "investigational" drugs for treatment purposes.

Sodium Testimony

The OCA Director testified before the House Committee on Science and Technology on the relationship of dietary salt to hypertension and cardiovascular disease.

The Director's testimony noted that a large proportion of this sodium-sensitive group are elderly and must live within very tight budgets on fixed incomes. The absence of convenient information on the sodium content of foods often limits their purchasing decisions to special dietary foods at premium prices.

Stating that the Government should not preempt consumer choice where market forces could solve the problem, the OCA Director proposed that the private sector accept responsibility both for disclosing sodium content in processed foods and reducing it to the extent feasible. She predicted that competition already begun on the basis of such health related information would ultimately achieve better results than a regulatory requirement, without increasing food costs.

Fraud Against the Elderly

The OCA Director testified on "Consumer Fraud and the Elderly" before the Senate Committee on Aging in Harrisburg, Pa. The Director stressed the need for constant and continuing efforts to arm older citizens with the information necessary to defeat fraud by eliminating the opportunity to be victimized.

The elderly and other home-bound consumers are particularly vulnerable to fraudulent door-to-door sale practices. OCA is working with the Direct Selling Association (DSA) to develop ways of protecting consumers and improving the integrity and professionalism of the industry. OCA and DSA are jointly writing standards on selling techniques and complaint resolution procedures. These will be presented to the DSA membership through training seminars and DSA's code of ethics.

CONSUMER COMPLAINTS

Even though OCA does not have statutory authority to take specific actions to resolve individual consumer complaints, it does have a responsibility to coordinate complaint handling activities at the Federal level, and to provide technical assistance to State and local consumer protection offices and businesses in their efforts to effectively resolve consumer's problems. OCA monitors and provides technical assistance to agencies and organizations to ensure that consumer complaints are handled effectively and efficiently.

OCA publishes materials designed to help consumers quickly locate the appropriate sources for assistance and most importantly, avoid problems by being smart, discriminating shoppers. OCA is currently updating and revising the Consumer's Resource Handbook. The handbook will highlight special consumer programs for the elderly.

Congressional Resource Exposition

OCA held its second constituent resources exposition, which was designed to help congressional staffers resolve constituents' consumer problems. In conjunction with the Expo, OCA prepared the Congressional Resource Handbook. Over 2,000 handbooks have been distributed to Congressional offices.

ThanaCAP

OCA recommended and the funeral industry has voted to establish ThanaCAP, an industrywide mechanism for handling complaints involving the funeral industry. ThanaCAP will be of particular benefit to the elderly.

Airline Complaints

OCA hosted a meeting of representatives from 17 major airlines to encourage the creation of an industrywide complaint handling mechanism after the Civil Aeronautics Board is abolished. The representatives were responsive to the idea and have decided to discuss the issue at the world airline customer service conference in Copenhagen. Senior citizens, who spend their leisure time traveling, would find the creation of this complaint handling mechanism very helpful.

INTRAGOVERNMENTAL ACTIVITIES

Interagency Committees

OCA was represented on the following interagency committees which have a special impact on the elderly:

Administration on Aging Interdepartmental Task Force on Information and Referral which assesses the Federal information and referral resources that exists and develops plans for improving and coordinating resources.

Federal Interagency Committee on International Year of Disabled Persons is responsible for planning activities for the year. The activities include: promoting national and international efforts to provide disabled persons with proper assistance, training, care and guidance; making available opportunities for suitable work; and ensuring their full integration in society.

Executive Order

Executive Order 12160—the Consumer's Executive Order—is a directive to Federal agencies to institute consumer programs that are effective and responsive to the needs of consumers. This action is a logical progression from the consumer representation plans of the 17 executive branch departments and agencies developed in 1976.

The order addressed the problems of citizens in achieving adequate participation in Government decisionmaking processes. For example, agencies are required to develop information materials to inform consumers about their procedures for participation. Elderly consumers have been identified as a constituent group which should be reached with information. Under the order, agencies must ensure that groups such as the elderly are being reached.

OUTREACH

The OCA Director was a member of the advisory council to the North American Regional Technical Meeting on Aging. The meeting was in preparation for the 1982 World Assembly on Aging.

The OCA Director has addressed and OCA has conducted workshops at conferences sponsored by aging organizations, including the National Council on Aging, National Center and Caucus on the Black Aged, Nassau County Senior Citizens Organization, and George Washington University "Symposium on Current Issues Affecting Older Women."

Health Care Conference

OCA sponsored a conference on "responding to the health care consumer" which stressed the importance, from a competitive standpoint, of providing quality health care for consumers at reasonable costs.

The conference brought together over 300 health care professionals from throughout the country. The conference was cosponsored with the Society of Patient Representatives of the American Hospital Association, Blue Cross and Blue Shield Associations, the Health Insurance Association of America, and the U.S. Public Health Service.

Officials from the health care industry expressed support for improved complaint handling. Since the elderly are one of the primary purchasers of health care, increased sensitivity and efficiency in the area of complaint handing will have a major impact on them.

Training Seminars

OCA held substantive issues training seminars for State and local consumer protection officials. The two sessions addressed the issues of credit and mail order problems. Future sessions will also address issues that are equally important to the elderly.

Low Income, Aging, and Disabled Consumer Conference

OCA sponsored a conference on "new independence for low income, aging, and disabled consumers." The conference was cosponsored with the National Center and Caucus on the Black Aged, Associacion Nacional Pro Personas Mayores, National Retired Teachers Association and American Association of Retired Persons, National Council on Aging and other educational, government, and consumer organizations.

One of the major objectives of the conference was to train community leaders in consumer education and government participation to help them work with low income, aging, and disabled consumers. The workshops that focused on the elderly were: "Older Americans as a resource: To themselves, to each other, to the community," "consumer education for funeral planning," "consumed mechanisms for assuring quality nursing home care," "independent living for the aging," and "food and the older consumer."

White House Conference on Aging

OCA cosponsored a White House Conference on Aging Mini-Conference on the Elderly Consumer with the American Association of Retired Persons and the National Retired Teachers Association. The conference brought together elderly consumers and professionals who work with the elderly. Conference paticipants identified specific consumer issues of importance to the elderly and developed recommendations which were submitted to the White House Conference on Aging.

OCA staff provided the White House Conference on Aging committees with resource information for delegates and observers.

Energy Conference

In February, OCA will sponsor a conference on "energy and the elderly" that will provide an opportuntiy for energy suppliers and organizations representing the elderly to work together to develop energy programs. The conference will be cosponsored with the American Association of Retired Persons and the National Retired Teachers Association. In addition to addressing issues such as energy conservation, energy model projects from throughout the country will be highlighted.

Information and Education

Consumer News, OCA's twice-a-month newsletter, carries articles of general interest to consumers. Many of the articles have discussed proposed legislation and regulations that affect elderly consumers. Also included were articles on eyeglasses, medical devices, the White House Conference on Aging, announcement of the President's proclamation designating May older Americans month, announcement of the National Council of Senior Citizens' legislative conference, a report on the Director's testimony at fraud hearings, and a report on an industrywide consumer complaint system for the funeral industry. In addition, Consumer News anounced the availability of a packet of new materials about funerals, alternatives to funerals, and laws for professionals who work with elderly consumers. This packet was funded by the Administration on Aging and sponsored by the Continental Association of Funeral and Memorial Societies.

OCA publishes a weekly news column, "Dear Consumer." Columns of particular interest to the elderly discussed how to prepare wills and how to choose a doctor.

The supply of the Consumer's Resource Handbook is almost exhausted, but approximately 600,000 copies were distributed in 1981. The handbook contains a section on aging and refers to other sections in the handbook of interest to the elderly such as health care, social security, and veterans affairs. The State and local directory section lists government offices responsible for coordinating services for the elderly. The Consumer's Resource Handbook is currently being updated and will also contain information of particular interest to the elderly.

OCA, in cooperation with the Consumer Information Center and the American Telephone and Telegraph Co., has published Direct Contacts for Consumers, an 18-page brochure which lists Federal tool-free telephone numbers by subject area and toll-free numbers maintained by State consumer offices. Also included are telephone numbers for Federal information centers, which can answer questions about the Federal Government. This brochure should be particularly helpful to the elderly.

OCA is working with the Senate Special Committee on Aging to develop a listing of programs specifically designed to help the elderly. The publication will highlight voluntary and low cost programs.

National Consumers Week

OCA will coordinate National Consumers Week which will highlight successful consumer education programs and focus public attention on the need for strengthened programs in the future. National Consumers Week is planned for April 25–May 1. There will be a Presidential proclamation and activities, including community classes, workshops, contests, exhibits and displays. Many of the activities will address issues of interest to the elderly.

ITEM 24. PENSION BENEFIT GUARANTY CORPORATION

DECEMBER 14, 1981.

DEAR MR. CHAIRMAN: I am pleased to submit the following information in response to your recent request for a report on our programs and services for the elderly in fiscal year 1981.

Title IV of the Employee Retirement Income Security Act of 1974 (ERISA) established the Pension Benefit Guaranty Corporation (PBGC) to administer a new plan termination insurance program covering most private sector, tax-qualified, defined benefit pension plans. The termination insurance covered both single-employer and multiemployer plans. However, as a result of amendments to ERISA enacted in September 1980, the program covering multiemployer plans was changed from termination insurance to plan insolvency insurance.

Under both insurance programs, PBGC's basic purpose is to guarantee the payment of retirement benefits to eligible plan participants. In view of this function, all of our programs have a direct bearing on the lives of the elderly.

The single-employer plan termination insurance program covers approximately 26 million participants in over 85,000 plans. Under this program, PBGC guarantees payment of vested benefits, subject to statutory limitations, if a plan covered by the program terminates without sufficient assets to provide all guaranteed benefits. In such a situation, PBGC will seek trusteeship of the plan and will make benefit payments, when due, from PBGC funds.

From enactment of ERISA through the end of fiscal year 1981, PBGC received a total of 36,308 notices of plan termination. Over 95 percent of these plans had sufficient assets to pay all guaranteed benefits, and, in accordance with ERISA, we issued notices of sufficiency authorizing plan administrators to distribute plan assets to participants. The Corporation confirms final distributions to insure that assets are allocated in accordance with statutory requirements.

By year's end we had become trustee of 660 plans for all but a few of which we had been unable to determine that plan assets were sufficient at termination to satisfy guaranteed benefits. These plans cover almost 71,000 vested participants and surviving beneficiaries. Under these plans, we paid monthly an average of over $4.8 million in benefits to 33,000 participants. Had PBGC not existed, many of these people might not have received any retirement benefits at all.

Prior to the 1980 amendments, ERISA had granted PBGC discretionary authority to guarantee payment of benefits provided under terminating multiemployer plans which satisfied certain specified conditions. Eight of the plans under trusteeship at the end of fiscal year 1981 were multiemployer plans for which PBGC had exercised its authority to guarantee benefits. These plans covered over 5,600 vested participants and surviving beneficiaries.

The new multiemployer plan insolvency insurance program established by the 1980 amendments covers approximately 8 million participants in nearly 2,000 plans. Under this program, PBGC guarantees payment of benefits by providing financial assistance to multiemployer plans which lack sufficient funds to pay benefits when due.

In fiscal year 1981, the Corporation provided financial assistance under the new insolvency insurance program for the first time. On June 29, 1981, PBGC announced that it would loan $311,310 to the Anthracite Health and Welfare Fund, which had encountered financial difficulties in late spring when employer contributions temporarily ceased as a result of a strike which began on May 1, 1981. PBGC's loan enabled the fund to pay the July pensions for approximately 10,300 coal miners retired from the anthracite industry. The strike ultimately was settled in time to enable the fund to pay the August pensions from its own funds. The loan is to be repaid by August 1983.

Since both insurance programs, and particularly the insolvency insurance program, are of relatively recent origin, PBGC is faced with a continuing need for development of regulations essential to the full implementation of both programs. The regulatory process continued in fiscal year 1981 with the issuance of a number of final and proposed regulations. Although most of these were technical in nature and directed primarily at plan administrators, several were of particular importance to plan participants.

With regard to the single-employer termination insurance program PBGC's most consequential regulatory accomplishment during the year was the concurrent issuance of four final regulations which together significantly advance our implementation of this program. These four regulations provide rules for plan administrators to follow in completing the major steps involved in terminating a plan with PBGC—valuation of plan benefits, allocation of plan assets, determination of plan sufficiency, and determination and payment of employer liability to PBGC. By facilitating the process of plan termination and the distribution of plan assets or, if necessary, PBGC's assumption of plan trusteeship, these regulations insure that participants will receive the benefits to which they are entitled with a minimum of delay and uncertainty.

In several instances, PBGC's efforts during fiscal year 1981 to amend previously issued final regulations were equally as important for plan participants as the final regulations issued during the year. One amendment which PBGC issued in proposed form would provide rules for plan administrators to follow in distributing any plan assets that remain after all plan benefits have been paid under terminating, sufficient, nonmultiemployer plans. ERISA provides that such residual assets may revert to the employer who sponsored the plan if, prior to termination, the plan provided for such a reversion. However, the law also requires that residual assets attributable to employee contributions must be distributed to the employees who made those contributions. The proposed amendment would enable a plan administrator to determine when residual assets may be returned to the plan sponsor, and when and how such assets must be returned to employees who contributed to the plan.

PBGC continued to develop one other amendment of considerable importance to participants and surviving beneficiaries entitled to benefits under terminating plans. This amendment would revise our regulations specifying the types and amounts of benefits guaranteed by PBGC. As amended, the regulations would include rules under which PBGC would guarantee payment of benefits to which a participant is entitled under the terms of ERISA, even though the participant's plan has not been amended to provide those benefits as required by law. The 1980 amendments to ERISA authorized PBGC to adopt such rules to protect the interests of plan participants whose employers disregarded the statutory requirements. Consequently, the new rules will enable PBGC to guarantee benefits which Congress had intended pension plans to provide, even if a terminating plan does not actually provide these benefits.

With regard to the insolvency insurance program for multiemployer plans PBGC has identified approximately 65 regulations which the 1980 amendments to ERISA either require or authorize us to develop. Of these, five regulations were issued during fiscal year 1981, and an additional 10 were being developed. Although these regulations are intended to provide purely technical guidance to plan administrators, they will be of indirect benefit to plan participants by assisting plan administrators in carrying out their responsibilities under the new insurance program.

Throughout the year we continued to expedite handling of sufficient terminating plans to allow distribution of assets by plan administrators to participants and beneficiaries with a minimum of delay. When we determined that a terminating plan did not have sufficient assets to provide all guaranteed benefits, top priority continued to be given to maintaining continuity of benefit payments. If plan assets were not adequate to avoid benefit interruption, PBGC assumed trusteeship quickly so benefit payments to retirees continued without interruption.

We also continued an interagency agreement with the Internal Revenue Service whereby we obtain current addresses of participants in terminated plans who are eligible to receive benefit payments but for whom neither PBGC nor the plan administrators (of terminating sufficient plans) have current addresses. This agreement has enabled us to locate at least 65 percent of the people whom we otherwise have been unable to find. Without this interagency cooperation, these people either would not have received their pension benefits or payments to them would have been delayed.

During the year legal challenges continued to be raised to our interpretations and administration of the statutory provisions governing the insurance programs. PBGC also found it necessary to initiate litigation to protect the insurance system and the interests of plan participants. Of the cases decided during the year, several resulted in our successful assertion of jurisdiction over underfunded terminating single-employer plans whose participants would have lost much of their benefits absent our intervention. Favorable determinations in other cases enabled us to collect substantial amounts of money due the insurance system, and to prevent improper distributions of plan assets.

In the multiemployer plan area, a number of court cases were initiated challenging the constitutionality of certain aspects of the new legislation. As of the end of the year no decisions had been rendered in any of these cases.

Finally, we continued our efforts to inform plan participants, employers who maintain plans, and others, of the nature of our guarantees and program requirements. Among other things, we simplified and updated a booklet which we had previously issued to answer the questions most frequently asked by plan participants about our termination insurance program. Almost 40,000 copies of the revised booklet were distributed upon request during the year.

Elderly persons and others wanting information on pension protection under our insurance programs may write to PBGC, Branch of Coverage and Inquiries (541), 2020 K Street, NW., Washington, D.C. 20006, or call (202) 254-4817 (this is not a toll-free number).

I hope this information will be helpful to you.

Sincerely,

ROBERT E. NAGLE,
Executive Director.

ITEM 25. POSTAL SERVICE

NOVEMBER 23, 1981.

DEAR MR. CHAIRMAN: This is in response to your letter of September 14, requesting that the Postal Service submit a report concerning "any and all matters pertaining to problems and opportunities of older people."

Misrepresentation of products and/or services by unscrupulous mail order promoters not only cheats the public, but it also damages the reputation of the legitimate mail order industry. Although fraudulent schemes through the mail are an extremely small segment of the total mail order industry, they materially affect the lives of many in this Nation who appreciate and need the convenience of shopping by mail.

Shopping by mail is especially convenient for senior citizens. There are several types of fraudulent promotions which, by their nature, tend to focus on them. These include work-at-home schemes, investment and job opportunity ventures, land and merchandise frauds, and spurious medical promotions.

Recognizing this, we have designated postal crimes against the elderly as one of our priority programs. We are actively engaged in prevention activities and in instances where we cannot prevent a fraud from occurring, we aggressively use civil and/or criminal statutes to halt those schemes which affect the elderly. The following describes some of our activities in more detail.

In an effort to heighten public awareness, we selected and trained postal inspectors across the country as consumer protection specialists. Working with other Federal and State agencies and with such groups as the American Association of Retired Persons (AARP), the mission of these inspectors is to educate and inform the public as to how they can avoid being victimized.

These inspectors are also working with the media, and have appeared on hundreds of television and radio interview programs and have prepared articles for numerous newspapers and magazines. Information programs are currently being developed to be taken to all 6,000 chapters of the AARP. In addition, we contact newspaper and magazine publishers to advise them of action taken by the Postal Service against fraudulent schemes which were promoted through advertisements placed in their respective publications.

When our preventive efforts fail, investigations are pursued for criminal prosecution under the Mail Fraud Statute, title 18, U.S. Code, section 1341, which provides penalties of up to 5 years in prison and a $1,000 fine to those who use or cause the mails to be used to further a fraudulent scheme.

We also investigate for action under the Civil False Representation Statute, title 39, U.S. Code, section 3005. This statute permits the Postal Service, upon proper showing before an administrative law judge, to withhold, and return to the sender, mail addressed to anyone who solicits moneys through the mails by false representations. In fiscal year 1981, we initiated such actions against 454 various promotions nationwide. In addition, the Postal Service may request the U.S. district court, in the State where the promotion receives mail, to issue a temporary restraining order. This, in effect, stops the delivery of mail until the administrative law judge renders a decision. (Enclosed are brief summaries of some of the schemes which affect senior citizens, and examples of specific steps we have taken in dealing with them.)

I hope this information will be useful to the Special Committee in preparing its 1981 report.

Sincerely,

William F. Bolger,
Postmaster General.

Enclosures.

Work-at-Home Schemes

Senior citizens living on fixed incomes are often enticed by work-at-home schemes. In an effort to expose these operations, we developed a brochure which describes the typical work-at-home scheme with cautions for the consumer. It also asks the consumer to notify us of suspicious advertising and has a tear-off card for this purpose. Since we issued the brochure in June 1980, we have been receiving approximately 50 reply cards per week identifying numerous promotions. Within the past year, we have put out of business through false representation orders, consent agreements, or criminal proceedings, about 3,500 of these false work-at-home promotions. Recently, we received another indication that we are making an impact in this area. The National Council of Better Business Bureaus advised that for the first half of fiscal year 1981, the number of complaints received for work-at-home schemes was down by 56 percent compared to the same period the previous year.

Medical Fraud

Through cleverly conceived advertising, promoters of fraudulent medical products make claims for all manner of miracle cures. Such false claims have caused the Postal Service to initiate action against 253 medical promotions in fiscal year 1981. But the problem goes beyond the loss of a few dollars. These products can do harm, as the victims may put off seeking needed medical attention by relying on the promised miracle cure. Recently, the Postal Service issued a brochure designed to warn people of fraudulent medical promotions. This pamphlet enlists the aid of potential victims by asking them to notify us of any suspicious advertisements.

Investment Swindles

Another growing problem which affects senior citizens is the broad spectrum of investment swindles. This involves a variety of schemes, including franchise and distributorship, investments in coins, gems, stocks, land sales, and a host of others. There are many legitimate investment opportunities available in thee areas, but this only serves to give the mail fraud operator a better climate in which to conduct a fraudulent promotion. A typical promotion involved a Tennessee firm which placed advertisements soliciting individuals on retirement or fixed incomes to raise earthworms in their backyards. For an initial investment of $2,500, victims were told they would receive earthworms to raise which would then be bought back at a large profit to the grower. None of these promises ever materialized. Over 2,000 victims lost $3.5 million to this fraud. The individuals responsible for this scheme were sentenced to 3 years in prison with probation ranging from 3 to 5 years.

ITEM 26. RAILROAD RETIREMENT BOARD

December 7, 1981.

Dear Mr. Chairman: In response to your letter of September 10, 1981, we are enclosing a statement summarizing major activities of the U.S. Railroad Retirement Board on aging during fiscal year 1981. We have also included information on significant legal decisions affecting the elderly under the Board's programs.

We look forward to your committee's report on "Development in Aging: 1981."

Sincerely,

BEATRICE EZERSKI,
For the Board.

Enclosure.

U.S. RAILROAD RETIREMENT BOARD

The U.S. Railroad Retirement Board is the Federal agency that administers a comprehensive social insurance and staff retirement system for railroad workers and their families, separate from, but closely coordinated with, the social security system. Programs administered by the Board include the following. (1) Old-age, survivor, and disability benefits under the Railroad Retirement Act; and (2) unemployment and sickness insurance benefits under the Railroad Unemployment Insurance Act. The Board also performs certain administrative services under the Federal health insurance (medicare) program with respect to aged and disabled railroad workers and eligible members of their families. In addition, the Board has administrative responsibility for certain employee protection measures provided by other Federal railroad legislation, such as the Regional Rail Reorganization Act, the Milwaukee Railroad Restructuring Act, the Rock Island Railroad Transition and Employee Assistance Act, and the Northeast Rail Service Act.

BENEFITS AND BENEFICIARIES

During fiscal year 1981, benefit payments under the railroad retirement and railroad unemployment insurance programs totaled $5.5 billion. Retirement and survivor benefit payments amounted to $5.3 billion, an increase of $556 million over the same period 1 year earlier. Unemployment and sickness benefit payments totaled $257.5 million, an increase of $45.3 million from the preceding fiscal year.

The number of beneficiaries on the retirement-survivor rolls on September 30, 1981, totaled 999,000. The majority (80 percent) were age 65 or older. At the end of the fiscal year, 448,000 retired employees were being paid a regular annuity averaging $568 a month, about $52 higher than a year earlier. In addition, 193,000 of these employees were being paid a supplemental railroad retirement annuity averaging $52 a month. Nearly 234,000 spouses of retired employees were receiving an average annuity of $251 a month at the end of fiscal 1981. Of the 327,000 survivors on the rolls, nearly 289,000 were aged widow(er)s receiving an average annuity of $401 a month. Some 859,000 individuals who were receiving or were eligible to receive monthly benefits under the Railroad Retirement Act were covered by hospital insurance under the medicare program at the end of fiscal 1981. Of these, 842,000 (98 percent) were also enrolled for supplemental medical insurance.

Unemployment and sickness benefits under the Railroad Unemployment Insurance Act were paid to 185,200 railroad employees during the fiscal year. However, only about $0.7 million (less than 1 percent) of the benefits went to individuals age 65 or older.

RAILROAD RETIREMENT LEGISLATION

By 1980, recurring double-digit inflation and recession combined with other factors placed financial stresses on the railroad retirement system, making it clear that additional financial measures were needed to maintain the system. Railroad retirement amendments were subsequently enacted on August 13, 1981, as part of the Omnibus Budget Reconciliation legislation signed into law by President Reagan. These amendments were generally effective October 1, 1981.

The amendments increased railroad retirement taxes on both rail employers and employees, provided the Railroad Retirement Board with authority to borrow funds if temporary cash-flow problems develop, and called for further financing recommendations.

Major changes in benefit provisions: (1) Revised the employee, spouse, and survivor formulas for annuity portions paid over and above social security levels, (2) continued certain employee and spouse cost-of-living increases and revised survivor cost-of-living increases, (3) broadened the current connection requirement applicable to certain career employee benefits, and (4) eliminated future supplemental annuity closing dates.

In addition, the new law provided benefits for divorced wives, surviving divorced wives, and remarried widows which are like those provided under the Social Security Act.

The amendments also require the Railroad Retirement Board to adjust future dual benefit windfall payments to annuitants with both railroad retirement and social security coverage. Payments will be limited to the amounts appropriated from general revenues for windfall benefits. This limitation has resulted in an initial 21 percent reduction in windfall benefit amounts. The further award of these dual benefit windfall payments is restricted to vested employees with dual coverage on their own earnings.

MAJOR RAILROAD RETIREMENT COURT DECISIONS

Denberg v. *The Railroad Retirement Board* is a class action which was filed in the U.S. District Court for the Northern District of Illinois. The plaintiffs seek spouse benefits, under the Railroad Retirement Act of 1974, for periods prior to March 1977, for those male spouses who were denied spouse annuities because of the dependency provision found in section 2(c)(3)(ii) of the act. The dependency provision was ruled unconstitutional in the case of *Railroad Retirement Board* v. *Kalina*, 431 U.S. 909 (1977). As a result of that decision, the Board has been paying husbands' and widowers' annuities, regardless of dependency, since March 1, 1977. On June 16, 1981, the court issued a decision in the *Denberg* case, granting the plaintiffs' motion for summary judgment and denying the Board's motion for summary judgment. The court ordered the Board to pay spouse annuities to class members retroactive to March 1974. The Board has appealed the court's order to the U.S. Court of Appeals for the Seventh Circuit.

In the case of *Linquist* v. *Patricia Roberts Harris and the Railroad Retirement Board*, brought before the U.S. District Court for the Western District of Missouri, the plaintiff, who receive a widow's annuity under the Railroad Retirement Act and an old-age benefit under the Social Security Act, is challenging the application of the excess earnings provisions to both her railroad retirement annuity and social security benefit. The plaintiff claims that the imposition of excess earnings deductions under both acts amounts to a "double deduction," whereby her total benefit under the two acts is reduced dollar for dollar for her excess earnings. The plaintiff is (1) seeking class certification of this action, and (2) requesting that the court order declaratory and injunctive relief against future application of this so-called "double deduction," as well as monetary relief for benefits deducted in the past resulting from application of this "double deduction." The Board has filed a motion to dismiss and a motion for summary judgment, contending that the court has no jurisdiction to review Board determinations and that the imposition of the "double deduction" is not unconstitutional.

INFORMATIONAL PROGRAMS

Informational conferences for railroad labor union officials are an integral part of the Board's public information program. At these conferences, Board representatives describe and discuss the benefits available under all the Board's programs. Through these conferences, the Board saves the thousands of work-hours which would otherwise be required to explain the Board's programs on an individual basis.

Seminars for railroad executives and managers are also conducted by the Board. These meetings are designed to facilitate communications and cooperation between railroads and the Board, as well as acquaint railroad officials with the Board and its programs. At these meetings, Board representatives review the Board's benefit programs, administration and financing, with special attention devoted to those areas in which both the Board and the railroads gain from better coordination.

ARTICLES

The Board's periodical, the RRB Quarterly Review, publishes articles on retired employees, their spouses, and survivors. During fiscal year 1981, the following articles relating to aging were published in the periodical: "Life Expectancy of Railroad Retirement Beneficiaries"; "Windfall Payments"; "Survivor Benefits to Widowed Mothers and Children"; "Employee Disability Retirements"; "A Brief Review of Fiscal Year 1980"; "Retirement and Survivor Benefit Operations"; "Legislative Developments"; "Administrative Developments"; and "Legal Rulings."

ITEM 27. SMALL BUSINESS ADMINISTRATION

DECEMBER 15, 1981.

DEAR MR. CHAIRMAN: In response to your request for information about the programs we have concerning older people, we are pleased to advise that the Small Business Administration has been active in promoting programs of interest to the aging.

During fiscal year 1981, SBA's Hartford District Office joined with the Connecticut State Department of Economic Development, the Connecticut Business and Industry Association, the chamber of commerce regional and local organizations, and the State of Connecticut Job Service agencies in supporting the State of Connecticut Department of Aging sponsored "Employment Information Seminar on Older Workers." This seminar was scheduled to assist small business employers to identify, recruit, and effectively utilize abilities of workers over age 55.

Additionally, SBA's involvement with the problems of the aging has been strengthened by our designating a member of our staff to represent the Small Business Administration on the Interdepartmental Task Force on Statistics on Aging and to assist the Administration on Aging to update their "Inventory on Federal Statistical Programs Relating to Older Persons." We have also designated our representative on the interdepartmental task force to serve as the SBA liaison to the White House Conference on Aging.

The Civil Rights Compliance Division of SBA's Office of Equal Employment Opportunity and Compliance assures nondiscrimination on the part of SBA program offices as well as recipients of financial assistance. Complaint of discrimination under the Age Discrimination Act are sent to the Federal Mediation and Conciliation Service for mediation prior to investigation of the complaints.

SBA continues to actively enforce regulation B (12 CFR 202) of the Federal Reserve System and its own requirements under the Equal Credit Opportunity Act, as amended. During fiscal year 1981, SBA monitored 25,888 recipients for nondiscrimination, including compliance with the Equal Credit Opportunity Act's prohibition against discrimination on the basis of age.

In 1964, the Small Business Administration established a volunteer program called the service corps of retired executive (SCORE). The objective of this program was to provide management assistance service to the small business community. In 1981, SCORE was integrated with the active corps of executives (ACE) so that the organization is now comprised of volunteers who are both active executives and retirees from the active business world who have business experience and are willing to share this knowledge and experience with others. SCORE and ACE provide a businessperson-to-businessperson advisory relationship. In addition to the invaluable service that is derived by the small business owner/operator, there is an added benefit tothe volunteers. SCORE and ACE members know that their aid is needed and their participation provides the volunteers with a sense of satisfaction for contributing his or her knowledge to help others.

SCORE and ACE volunteers have counseled over 1 million small businesses since 1964 and the organization has grown from the initial 1,000 members to its current membership of 10,832 organized into 396 chapters located throughout the United States. In fiscal year 1981, SCORE and ACE volunteers counseled over 130,000 small business owner/operators.

Sincerely,

MICHAEL CARDENAS, *Administrator.*

ITEM 28. VETERANS ADMINISTRATION

DECEMBER 16, 1981.

DEAR MR. CHAIRMAN: I am happy to respond to your request of September 10, 1981, to provide you with a report of the Veterans' Administration's activities which concerns themselves with the aging veteran.

The Veterans Administration has developed a comprehensive, high-quality system that provides health care in hospital, outpatient and long-term care facilities for more than 50,000 aged veterans every day. In addition, the VA provides all or part of the income for more than 1.6 million persons age 65 and over.

I trust that this information will be useful to your committee.

Sincerely,

ROBERT P. NIMMO, *Administrator.*

Enclosure.

1. INTRODUCTION

The Veterans Administration is now faced with the problem of caring for a great many older veterans. Increasing age brings with it not only need for long-term care but for acute medical care as well. Older people now account for more than twice as many hospital admissions and twice as many hospital days, when admitted, as their younger counterparts. There is a great need for long-term care facilities to care for the aging veteran, but there is also an accompanying need for acute care since virtually all of the veterans in long-term care facilities will look to the VA for their acute care which may supervene. Further, the length of stay of veterans in hospitals, which has been decreasing over the years, now appears to be "bottoming out" because the reparative and restorative processes for older people take longer than for their younger colleagues. In 1980, approximately 30 percent of all of the resources—hospital, outpatient, and extended care—went to veterans who were 65 years of age or over. By 1990, the proportion will be about 40 percent.

Extended care bridges full hospital care and independent living with a diversity of programs. The VA had about 50,000 veterans in extended care programs on a typical day in fiscal year 1981, some 47 percent of whom were age 65 and over. The increasing number and diversity of extended care programs in the VA parallels that in the Nation.

The VA program for extended care and aging in the 1980's revolves around four major objectives for this area. The first is to improve the quality of care and life for patients of all ages in the VA. The second is to improve the utilization of the specific VA programs and their management through lower costs associated with improved staffing, management, patient selection, and by the development of alternatives to existing programs. The third is to increase the number of extended care facilities and to improve existing ones. The fourth, which cuts across all others, is to provide the Nation with model programs of long-term care, trained personnel in geriatrics and gerontology, and substantial amounts of research in basic and applied gerontology. Education and training are intimately involved in all of these objectives.

2. EXTENDED CARE PROGRAMS

VA NURSING HOME CARE

The nursing home care units located in VA medical centers provided skilled nursing care and related medical services, as well as opportunities for social, diversional, recreational, and spiritual activities. Nuring home patients typically require a prolonged period of nursing supervision and rehabilitation to attain and maintain optimal function.

In fiscal year 1981, 13,554 veterans were treated in VA nursing homes, which had an average daily census of 8,145.

Three new 120-bed nursing home care units were activated at VA medical centers in Martinsburg, W. Va., Memphis, Tenn., and Temple, Tex. These and other changes resulted in a net increase of 477 operating beds for a total of 8,973 beds at the end of fiscal year 1981 at 95 VA medical centers.

COMMUNITY NURSING HOME CARE

This is a contract program to aid veterans who require skilled or intermediate nursing care in making the transition from a hospital to the community. Veterans requiring nursing home care for a service-connected condition may be placed at VA expense for as long as the nursing care need exists, while nonservice-connected veterans may be placed in community facilities at VA expense for a period not to exceed 6 months. The program requires assessment of participating facilities and followup visits to veterans by teams from the VA medical centers.

In an effort to reduce unnecessary duplication in the assessment of nursing homes, and to reduce the cost of a multimember team assessment of their homes, the VA has arranged to make use of inspections conducted for medicare or medicaid certification. To do so, the VA obtains copies of the medicare/medicaid inspection documents and confirms that the home complies with standards. A miniteam of a social worker and a nurse then make an onsite visit to the home to evaluate the quality of care, the quality of life, and to describe the general characteristics of the facility.

In fiscal year 1981, 28,242 veterans were treated in approximately 2,900 community nursing homes in the 50 States and Puerto Rico. These facilities had an average daily census of 8,348.

VA DOMICILIARY CARE

Domiciliary care in VA facilities provides necessary medical and other professional care for eligible ambuatory veterans who are disabled by age, disease, or injury and are in need of care but do not require hospitalization or the skilled nursing services of a nursing home.

New program directions have created a better quality of life for veterans requiring prolonged domiciliary care and have prepared veterans returning to community living for active participation in various community resources. Special attention is being given to older veterans in domiciliaries with a focus on keeping them active and productive in the domiciliary as well as encouraging their integration into existing senior centers and other resources in the community.

In fiscal year 1981, 14,877 veterans were treated in VA domiciliaries which had an average daily census of 7,353.

Replacement domiciliary facilities at VA medical centers in Bay Pines, Fla., Martinsburg, W. Va., and Dayton, Ohio, were activated during fiscal year 1981. Bulit on the same plan as the facility at Wood, Wis., the program emphasizes an active rehabilitative approach.

Special attention was paid to the development of long-term care programs at the annual domiciliary conference with an emphasis on the older veteran. Patients at several domiciliaries are involved in senior center activities in the community as part of a focus on community integration. Other specialized programs in which older veterans are involved include foster grandparents, handyman assistance to senior citizens in the community, and adopt-a-vet.

STATE VETERANS' HOMES

The State home program has grown from 11 homes in 11 States in 1888 to 44 State homes (one of which has three annexes) in 31 States and the District of Columbia. Currently, a total of 17,015 beds are authorized to provide hospital, nursing home, and domiciliary care.

The VA's relationship to State veterans' home is based on two grant programs. One is a per diem program which enables the VA to assist the State in providing care to veterans eligible for VA care who are furnished domiciliary, nursing home, or hospital care in State home facilities. The other grant program provides VA assistance with up to 65 percent Federal funding in the construction of new domiciliary and nursing home care facilities, and the expansion, remodeling, or alteration of existing facilities.

During fiscal year 1981, the State veterans' homes maintained an average daily census of 5,855 nursing home, 4,572 domiciliary, and 881 hospital patients.

In fiscal year 1981, a second State home for Michigan was established at Marquette, and Nebraska opened a third annex at Omaha. New construction resulted in the addition of a 180-bed nursing home facility at Marshalltown, Iowa, and a 250-bed nursing home facility at Minneapolis, Minn. The VA also obligated funds in fiscal year 1981 totaling $13 million for construction and renovation projects including a new State home for West Virginia, consisting of 200 domiciliary beds.

HOSPITAL BASED HOME CARE

This program allows for an early discharge of veterans with chronic illness to their own homes and reduces readmissions to the hospital. The family provides the necessary personal care under coordinated supervision of a hospital based multidisciplinary treatment team. The team provides the medical, nursing, social, rehabilitation and dietetic regimens as well as the training of family members and the patient. Thirty VA medical centers are providing hospital based home care services. More acute care beds in hospitals are made available by providing increased days of care in the home.

In fiscal year 1981, 145,000 home visits were made by health professionals. Over 5,000 patients were treated, of which about 20 percent were terminal cancer patients. Eleven percent of these terminal patients died in their own homes while receiving support from the hospital based home care team.

ADULT DAY CARE

Staff in numerous VA medical centers have expressed strong interest in the value of adult day care programs in facilitating the return of older veterans to their own homes, to shorten the length of stay in acute beds, and to provide an environment in which these veterans can continue rehabilitation programs among their peers in the community. Several program models are in operation. VAMC North Chicago has a comprehensive program located on the medical center grounds. The VA program at the medical center at Loma Linda functions in a nearby community in conjunction with the local American Legion post. The program is licensed as an adult day health program in the State of California. Other program models are in operation at VA medical centers located in American Lake, Wash., and Palo Alto (Menlo Park Division), Calif., and at the Boston Outpatient Clinic.

RESIDENTIAL CARE (FORMERLY PERSONAL CARE HOME PROGRAM)

This program provides residential care, including room, board, personal care and general health care supervision to veterans who do not require hospital or nursing home care but who, because of health conditions, are not able to resume independent living and have no suitable family resources to provide the needed care. All homes are inspected by a VA multidisciplinary team prior to incorporation into the program and annually thereafter. Care is provided in private homes selected by the VA, at the veteran's own expense. Veterans receive monthly followup visits from VA social workers and other health care professionals, and are outpatients of the local VA facilities. An approximate average daily census of 12,500 was maintained in this program throughout fiscal year 1981.

GERIATRIC RESEARCH, EDUCATION, AND CLINICAL CENTERS (GRECC'S)

The GRECC program consists of eight centers and represents another aspect of the multifaceted VA response to the health care needs of aging veterans. It serves as a mechanism for attracting and developing superior staff into the field of gerontology and geriatrics. GRECC activities have been directed towards utilizing and redirecting existing resources for geriatric care, and advancing and integrating into the VA system clinical, research and educational achievement in geriatrics and gerontology. As a part of the program, GRECC's have been developing geriatric evaluation units (GEU), usually of 10 to 30 beds, for intensive diagnosis and therapy. Four GRECC's have developed GEU's with a broad base in general internal medicine.

Each center typically emphasizes one area of research relevant to aging. For example, one has developed a cardiopulmonary function evaluation unit, and three others, all with neuropsychiatric orientation, are focusing on chronic neurological diseases and organic dementias, including Alzheimer's type. GRECC professionals have produced well over 500 scientific publications since the beginning of the program in fiscal year 1975. GRECC's have reported the award of over $6 million in research funding during that same period. Over $1.5 million was awarded from the VA through the merit review process in fiscal year 1981. Since fiscal year 1975, the GRECC's have also received awards of approximately $3.5 million from other Federal agencies and private foundations. With the enactment of Public Law 96–330 and the creation of the Geriatrics and Gerontology Advisory Committee (GGAC), the GRECC's will be evaluated formally during the current fiscal year by both the committee, through a site visit process, and by the Department of Medicine and Surgery through its own evaluation process.

INFORMATION AND REFERRAL PROGRAM

The VA continues to participate actively in coordinative endeavors with Federal agencies on behalf of elderly veterans to provide information and referral services (Interdepartmental Task Force on Information and Referral) to minimize duplication of effort and to promote efficient use of resources. During fiscal year 1981, the VA placed new emphasis on the information and referral program as a system of planning, coordinating and maintaining a network for the provision of services to veterans through community agencies, and for making the community aware of health care benefits for eligible veterans.

3. MEDICAL SERVICE

In 1981, as in previous years, the Medical Service in VA facilities and the VA central office has continued its efforts to improve the overall quality of medical care. Older veterans can be expected to benefit from the improvement achieved, since they constitute a significant and growing segment of the VA patient population. Also, some activities specifically related to geriatric patients were conducted during 1981.

Policies and procedures for surveillance of patients with cardiac pacemakers, a large proportion of whom are in older age groups, continue to be developed. Two VA medical centers are continuing to study mentation in aging veterans both on and off treatment for high systolic blood pressure. A preliminary report of this study should be available in fiscal year 1982. The special VA centers for handling rheumatology-immunology and cardiopulmonary rehabilitation problems have continued their growth during 1981. Further attention has been directed to the nutritional needs of patients, including those in older age groups. Immunizations to prevent certain infectious diseases, such as influenza and pneumococcal disease, are provided to aged veterans as well as other groups of patients according to national recommendations.

During the past year, the central office Medical Service staff has participated in activities of the DM&S Committee on Health Services to the Older Veteran. This included obtaining output from selected field facilities and formulating recommendations for departmental action. Also, Medical Service participated in a recently held meeting at the Sepulveda VA Medical Center to discuss the establishment of geriatric evaluation units (GEU's) throughout the VA system.

4. Mental Health and Behavioral Sciences Service

A focus on the mental health of the aging veteran is an important facet of the VA health care program. The Veterans Administration facilities for the care of older veterans are principally in the extended care programs, the Medical Service and the Psychiatry Service. Many of the patients in intermediate medical care and extended care facilities have a psychiatric diagnosis as well as some physical disability. On a given day, the Medical Service in extended hospital care has about 10,500 patients (about 50 percent of these also have a psychiatric diagnosis). Of this group, 51 percent are 65 years of age or over. It should also be noted that some of the extended care programs report increasing numbers of admissions for long-term medical care directly from the community and not as transfers from one of the VA medical center wards or clinics.

Of the patients with a psychiatric diagnosis who are age 65 and older, 76 percent are on psychiatric wards and 24 percent are on other wards, principally medicine. Many other older psychiatric patients are in VA and community nursing home facilities, VA domiciliaries and residential care homes.

The Veterans Administration supports, through its research program, research on problems in long-term psychiatric disease, such as senile dementia and alcoholism, as well as other diseases common among aging individuals.

Geropsychiatric programs at the VA medical centers in Little Rock and North Little Rock, Ark.; Lyons, N.J.; Northport, N.Y.; Salisbury, N.C.; American Lake (Tacoma), Wash.; Brockton, Mass.; Coatesville, Pa.; Knoxville, Iowa; Los Angeles (Brentwood), Calif.; Murfreesboro, Tenn.; Salem, Va.; Togus, Maine; and Waco, Tex., have programs modified to meet the unit's special needs of geriatric patients. They include attention to physical, mental, and social activity of a stimulating type. It is believed that some of these patients will make a better adjustment in the community and, with proper treatment, show improvement in their physical and mental state if kept physically and mentally active. Psychiatry also has geriatric day care programs at VA medical centers in Palo Alto, Calif.; North Chicago, Ill.; Outpatient Clinic, Boston, Mass.; and Loma Linda, Calif. The number of geriatric day care programs is expected to increase as staff and support become available.

5. Social Work Service

The growing needs of the elderly "at risk" veteran population continue to be a priority of Social Work Service. Social workers at all medical centers have developed linkage with, and serve as, liaison staff to the areawide agencies on aging for the purpose of improving the coordination of VA and community services to the elderly; identifying gaps in the community service network; and working cooperatively with other agencies to meet the needs of the elderly, particularly those with significant social and health care problems. As a corollary to this, councils of social work chiefs at the medical district level are developing baseline data as part of the medical district initiated program planning process which will assist the agency in meeting the challenge posed by older veterans during the 1980's. Additional information relating to the needs of the aging veteran is being incorporated into our national reporting system.

An agreement has been reached between the Department of Medicine and Surgery and the Department of Veterans Benefits, which will facilitate the delivery and coordination of services to incompetent, older veterans living in community nursing homes and residential care homes under social work supervision. In addition, joint collaboration and consultation will enhance working relationships, improve the decision making process and result in significant cost savings through a more effective use of staffing resources.

The significant contribution of Social Work Service in the formation of an advisory committee on geriatric health services planning within VA central office has contributed to the assessment of health care requirements and service delivery plans for geriatric health services, and should provide impetus to the development of multidisciplinary geriatric advisory councils at the medical center level.

The development of pilot independent living centers at six VA medical centers has placed emphasis on the need to implement innovative approaches to assist veterans with severe medical and/or psychiatric disabilities who require an extensive community support system. Social workers, as part of the core staffing of these units, are a key resource in developing noninstitutional models which will integrate VA medical center and community resources. It is anticipated that a significant number of older veterans will receive services under this program.

Social workers continue to function as advocates for the elderly through participation in the development of multidisciplinary assessment and treatment models which emphasize the need to focus on those special needs. The development of a range of cost-effective alternatives to institutional care that meet quality of life and quality of care standards continues to be emphasized as a basic component of comprehensive health care planning.

Activation of a VA consumer affairs program during fiscal year 1981 has supported the increased involvement of social workers as consumer advocates in the areas of admission screening, treatment and discharge planning, and the provision of followup services to older veterans placed in the community. The prevention of unnecessary medical center care through improved services to elderly veterans remaining in their own homes during fiscal year 1981 provided for better utilization of medical center beds while supporting the right of veterans to remain in their own homes through the provision of appropriate community and/or VA services.

The appointment of visual impairment service team coordinates at 12 medical centers enhanced the development of a more comprehensive program of services to blinded veterans, many of whom are 65 and older. The coordinators, who are responsible to the Chief, Social Work Service, at designated medical centers, assumed a major role in the integration of VA and community services to visually impaired veterans and their families. A new approach utilized by social workers in one medical center involved a telephone group counseling program for blinded veterans which reduced the psychological isolation experienced by veterans who live in areas distant from VAMC's, while providing information and support which would otherwise not be readily available.

The day ambulatory service for health (DASH) program was initiated under the leadership of Social Work Service at the VAMC at Loma Linda, Calif., to meet the needs of the frail elderly who otherwise might have to face inappropriate institutional care. In 1980, DASH was relocated to Yucaipa, Calif., a community with a high concentration of senior citizens. The American Legion post made space available for the program under which services are available to nonveterans as well as veterans. VA and community health, social, educational, and recreational services have been integrated and the program has been licensed by the State as an adult day health center. It is anticipated that this health care system for the elderly will be developed to meet the needs of the elderly at other selected locations across the country.

Older veterans at a number of medical centers are developing a role as service providers which focuses on the potential of the elderly to make a significant contribution to the welfare of the community. Areas of service include sponsorship of Little League teams, adopting needy families at Christmastime through financial support, and providing voluntary services to residents in community settings.

Reduction in community services resulting from budgetary constraints makes it imperative that staffing resources for the "at risk" elderly be deployed as effectively and efficiently as possible. Social work will pursue the continued development of community based outreach and ambulatory health services for elderly veterans.

6. Rehabilitation Medicine Service

As a result of a VA-wide Rehabilitation Medicine Service (RMS) conference on geriatric rehabilitation in mid-198[illegible], the focus on treatment programs for the aging veteran has increased. Regional medical education centers (RMEC's) at Long Beach, Calif., Salt Lake City, Utah, and Northport, N.Y., as well as the rehabilitation engineering education program (REEP) at Los Angeles, Calif., have either contributed continuing education programs in geriatric rehabilitation or have initiated plans to bring RMS personnel into future courses. Professional organizations representing RMS therapist specialties have highlighted geriatric rehabilitation as their theme for 1981 meetings (e.g., American Corrective Therapy Association and American Occupational Therapy Association). Many VA therapists were able to participate in these disciplinary conferences. A representative from RMS in VA central office attended the September 1981, President's Council on Physical Fitness and Aging, held in Washington, D.C.—an event which emphasized the need for exercise and movement as one reaches the later years.

In an ongoing survey of Rehabilitation Medicine Service programs in the field, additional emphasis on geriatric care has been noted. Lifeskills programs and increased emphasis on sensory motor integration activities are active at the VA medical centers in Waco, Tex., and Perry Point, Md. Reality orientation and remotivation activities for the aging veteran are stressed at Murfreesboro, Tenn., and Perry Point, Md. The VA medical center in Sepulveda, Calif., has developed the creative living center which involves geropsychiatric patients attempting to adapt to the stresses of growing older. Occupational therapy joins a full multidisciplinary team in this developing project. The corrective therapy staff at this center also developed a "sports day," with wheelchair events for the older group of veterans. Both Sepulveda and VA St. Cloud, Minn., have developed and perfected an interactional program where local elementary or high school students meet and relate with members of the VA's nursing home care unit population.

Horticultural therapy has provided a meaningful, avocational interest for the older, hospitalized veteran who was either raised in a rural setting or enjoys the creative, yet soothing, experience of working in the soil. Independent living centers have been officially initiated at six sites throughout the Nation in which geriatric veterans attempt to make the difficult transition from hospital to community living. Compensated work therapy (CWT) programs have recently been incorporated at a few VA domiciliaries (VAMC's Bay Pines, Fla., Martinsburg, W. Va., and Los Angeles (Wadsworth), Calif., with additional starts contemplated in current and future years.

Activities provided by Rehabilitation Medicine Service are conducive to full participation by most members of the medical care staff. The multidisciplinary approach to rehabilitation of the aging veteran has been encouraged and should result in innovative, high quality and satisfying experiences for this population. It is anticipated that these programs will continue to expand throughout the VA health care system.

7. Nursing Service

Nursing services comprise the majority of the health care services required by the elderly veteran. In preparation for the ever increasing numbers of older veterans requiring our care and in view of the current nursing shortage, Central Office Nursing Service has written recruitment letters to all the clinical nurse specialists who received training support from the VA. Recruitment letters also went to the 29 nursing schools who have gerontological nursing content at the masters level.

The need for innovative programing in gerontological nursing was reflected in an informal survey of 94 nursing homes which was completed this year. These data have led to proposals for a centralized training program for supervisors of nursing home care units and for gerontological nurse fellowship programs. Task forces to provide advice on the process and content of these potential programs are planned for early in fiscal year 1982. In addition, at least three field stations have collaborated in their affiliated colleges of nursing to submit grant proposals for the Robert Wood Johnson teaching nursing home program. Others are awaiting announcement of the National Institute of Aging program in order to plan collaboratively with medicine and other disciplines to develop an academically attractive system of care delivery within specific nursing home settings.

A list of masters prepared clinical nurse specialists in gerontology has been made; efforts to form a system wide network can now proceed. These nurses are essential to educational efforts at the district level and at regional medical education centers (RMEC's). They can provide valuable input in formulating systemwide programs for nursing care of the elderly, including the establishment of nurse administered primary care clinics for elderly veterans. This type of clinic is a cost-effective method for coordinating the care of older veterans who frequently must seek services from a variety and number of specialty clinics at each outpatient visit.

The need for improved community services for the aged veteran and family has been identified as an area in which nursing has a potentially significant contribution. Several issues have been developed into proposals for demonstration of community nursing programs. Health care instruction for patient/family/caregiver is seen as an area of need and one that the nurse could meet capably. Preventive health care is a second aspect of need for which nursing could assume leadership. A void now exists in both areas.

Nursing Service is committed to its responsibilities and obligations as the major provider of health care services to the elderly. Speakers have been provided to two RMEC conferences on implementing "Standards and Educational Guidelines for Gerontological Nursing Practice." (M-2, part V, G-14). Nurses have also participated in many other significant meetings, including the long-term care foundation conference and the national gerontological nursing symposium.

8. Dietetic Service

Dietetic Service has identified the problems most frequently encountered in the nutritional care of aged veteran patients as the following: (1) Poor dentition; (2) depression; (3) physiological changes, including diminished taste, vision and smell; (4) insufficient dietetic and nursing staff; (5) financial limitations; (6) constipation; (7) resistance to change and fixed eating patterns; (8) inadequate fluid intake; (9) dysphagia; and (10) difficulty with self-feeding.

In anticipation of the rapidly increasing geriatric veteran population, Dietetic Service is preparing geriatric nutrition guidelines for use of dietetic staff VA-wide. These guidelines are designed to increase the awareness of staff to the extreme vulnerability of aged veterans to nutritional problems and to give suggested approaches to providing optimum nutritional care which will address these problems. VA dietitians who have worked extensively in geriatric nutritional care have surveyed the food preferences of aged patients and made many suggestions for improving the food service for them. This information will be disseminated VA-wide.

Assessing nutritional status is a problem to the dietitian because of the unavailability of appropriate standards for anthropometric measurements for geriatric patients. Other problems related to this include, having to adjust measurements for contractures, amputations, etc., problems with instruments used, difficulty interpreting results, and uncooperative patients. Anthropometric measurements in the elderly should be researched. A proposal for such research to be conducted at specific VA medical centers is under development.

Several of the veterans' nutritional problems listed above contribute greatly to the malnutrition frequently found in aged veterans upon admission to VA medical centers or shortly thereafter due to the ravages of acute illness and/or multiple chronic diseases. Studies of geriatric veterans, to determine the incidence of nutrition related anemias and/or protein malnutrition with decreased immune function, have been proposed by dietitians in selected VA medical centers. Such studies are needed and will be pursued if resources are available.

All efforts of dietitians to respond to the nutritional problems of geriatric patients must be integrated with physicians, nurses, pharmacists, and social workers. A multidisciplinary approach to geriatric patient care is essential as geriatric problems compound themselves and require the expertise of many health care professionals. Hence, it is essential that educational programs to improve the competence of professional staff responsible for geriatric care be designed to allow many disciplines to learn together. Dietitians are participating in VA and non-VA educational programs to improve their competence in providing nutritional care to geriatric veterans, as inpatients, in ambulatory care, and in VA community care programs.

9. Voluntary Service

In keeping with its role of volunteer support for treatment programs of the Department of Medicine and Surgery, Voluntary Service has continued a steady increase in services to the aging patient.

At central office, the service is represented on a select liaison group to the agency's Advisory Committee on Geriatric Health Services Planning and Programs. A major function of this liaison group is encouragement of medical center staff to initiate and develop programs for the aging in their own fields of responsibility.

In addition to this function, Voluntary Service is encouraging the interest and initiative of the volunteers themselves, and of their organizations, both local and national. At the local level, volunteers are being invited to participate in medical center seminars on the effects of aging. Nationally, workshops conducted and planned for leadership volunteers attending annual meetings of the Voluntary Service National Advisory Committee in fiscal year 1981 and 1982 have included hospice care and dealing effectively with the older patient.

Staff planning for hospice, nursing home care, and other programs related to the aging patient has demonstrated an encouraging awareness of the useful role of volunteers. In the initiation of hospice porgrams, for example, volunteers are being asked to participate from the earliest planning stage to the final implementation.

The Voluntary Service program continues to recruit volunteers of retirement and postretirement age, with awareness that their activity in the medical centers is beneficial not only to the patients, families and staff, but to the volunteers themselves. Every effort is made to adapt to special requirements of advanced age or infirmity, often by adapting their assignments and in, at least in one instance, the popular escort service for wheelchair and litter patients by securing motorized carts which enable the volunteers to remain usefully active.

10. DENTISTRY

The ever increasing commitment that the Veterans Administration has in the care of the aging is well recognized. In assessing the impact upon the activities and resources of the VA health care system, it is imperative that the dental needs of the aging veteran be considered as an integral part of the program.

The incidence of certain oral diseases, ranging from periodontitis to cancer, increases dramatically with age and it is essential to identify and care for these problems. Freedom from intraoral or tooth-related pain and irritation, of course, is basic. Establishment and maintenance of a functional dentition is helpful to the digestive and nutritive processes, and essential for allowing an interesting and palatable diet—a factor in quality of life. Likewise, the patient's self-image may be significantly affected, positively or negatively, by the appearance of his or her mouth and teeth. Similarly, there is a contribution effect of the dentition in the ability to speak distinctly. As in other types of medical and surgical care, the geriatric patient requires modifications in type and extent of dental treatment.

For these reasons, the Veterans Administration is currently taking steps to assure that their dentists and dental staffs will be adequately prepared to meet the challenge of caring for the aging veteran. A needs assessment instrument is being readied for distribution to field facilities. Its analysis will provide the basis for the development of educational materials and courses in gerontology and geriatric dentistry. A 2-year fellowship in geriatric dentistry, to be offered on a continuing basis at several VA facilities, is presently in the final stages of planning. Finally, dentistry has been directly involved in the VA central office planning processes committed to health services for the aging veteran and to the special effort related to the geriatric research, education, and clinical centers (GRECC's).

11. MEDICAL RESEARCH SERVICE

In the year 1900, 4 percent of all Americans were 65 years old or older. At present, that figure stands at more than 10 percent, or 23 million people. In 50 years, it is expected that one in five Americans will be 65 or older.

The Veterans Administration is the largest single dispenser of health care in this country. There are over 30 million veterans. Of these, approximately 3 million are now 65 or over, and by the year 2000, this population will have increased to 8 million.

These numbers emphasize the need to plan now to deal with the considerable social, economic and personal consequences of this graying of the population. The task at hand is to ensure that the elderly do more than just survive to advanced age. A much larger proportion of their extended lives must be made creative, productive, and of value to the individual and to society.

To this end, we need more knowledge about aging, per se, and the disease states which accompany and interact with the aging process. In addition, there is a need to improve the economic and social status of the majority of the elderly and to examine the negative attitudes and myths which weigh heavily on the aged.

Aware of its obligations to the older veteran, the Veterans Administration has long given strong support to research on the biological, clinical, and psychosocial aspect of aging. These efforts have been manifested in the establishment of geriatric research, education, and clinical centers (GRECC's), the geriatric physician fellowship program, the interdisciplinary team training program in geriatrics, and in the assignment of high priorities to research in the biology of aging and the development of innovative health care delivery systems. The results of certain of this research are presented below.

BASIC SCIENCE STUDIES

Ann Arbor VA Medical Center.—Digestive problems increase and are more complex in the elderly. Dr. S. K. Kim has shown that there is a significant decrease in the synthesis of the digestive enzyme alpha-amylase in the salivary glands of old rats.

Audie Murphy VA Medical Center.—G. Liepa et al. have demonstrated that restriction of food intake of Fischer 344 male rats markedly increased median life expectancy. Lifelong food restriction did not influence the serum levels of cholesterol and phospholipid in young animals, but did delay the age-related increase in their concentrations. These data clearly show that food restriction delays the age-related change of several physiological factors and thus can modify disease and prolong life.

Bay Pines VA Medical Center.—Hormonal and neural functions are programed to vary in intensity with time during the day in anticipation of periods of maximum activity and rest. Dr. H. Samis has demonstrated an age-related decline in the function of this biological clock in *Drosophilia melanogaster*, suggesting that the senescent organism is less able to adjust to variations in level of activity required during the day.

Bedford VA Medical Center.—It has been estimated that dementia in the elderly costs approximately $12 billion per year in nursing home care alone. The most common cause of dementia is Alzheimer's disease. Dr. K. Nandy has shown that although caloric reduction extended the median life span of mice, it had no significant effect on the age-related increase in neuronal lipofuscin content, a diagnostic feature of Alzheimer's disease. Dr. Nandy also found that brain reactive antibodies appeared earlier in aging mice subject to autoimmune disease. Dr. M. Malone has conducted chemical studies on lipofuscin which have shown no changes in proteolipid or basic protein content but have revealed on lipid analysis increased amounts of p-ethanolamine, p-inositides, and p-choline.

Gainesville VA Medical Center.—In Alzheimer's disease, the more brain plaques patients have the more demented they are, and the lower the activity of choline acetyl transferase and acetylcholine in the brain. Dr. G. Freund has shown that the number of synaptic cholinergic receptors in the brain of mice decreases with age after 18 months.

Long Beach VA Medical Center.—Dr. D. Hollander demonstrated that the absorption of vitamin A is significantly increased in aged rats raising the possibility of similar changes in absorption of other fat soluble nutrients and drugs in the aged human. Vitamin A is important in preserving epithelial integrity and in vision. Vitamin E, another fat soluble vitamin, is a potent biological antioxidant and may be involved in the retardation of aging.

Palo Alto VA Medical Center.—Dr. T. Okarma has demonstrated significant changes in the capacity of older guinea pigs to metabolize a major psychoactive drug, chlorpromazine, because of age-related declines in the activities of the liver enzyme systems responsible for N-demethylation and sulfoxidation. Other studies of the GRECC have shown that pancreatic islets of Langerhans increase in size as rats age and that this is associated with a proportionate increase in the number of insulin producing cells and in the volume of mature insulin granules within these cells. However, an age-related decrease was found in the amount of insulin released following stimulation with glucose or leucine. Other studies showed that these changes were not due to the aging process per se, but were associated with the obesity and diminished activity characteristic of the elderly rat. In related work, efforts were made to determine why plasma triglyceride (TG) levels rise with age. Two basic changes in TG kinetics were noted. First, the efficiency with which the liver esterifies free fatty acids (FFA) and secretes TG decreases with age in the rat. However, this is more than compensated for by an increase in FFA concentration resulting in an increase in TG secretion. Second, TG clearance with plasma does not increase proportionately. The reason for this is not clear.

St. Louis VA Medical Center GRECC.—Dr. H. Armbrecht, et al., have found that aged rats respond abnormally to calcium deprivation to a greater degree because of their diminished capacity to form the most active vitamin D molecule. This has relevance to calcium metabolism in general and to osteoporosis in particular.

San Francisco VA Medical Center.—Antibodies to normal tissue components are found not uncommonly in the sera of elderly humans and it has been suggested that autoimmune reactions contribute significantly to the development of age-associated diseases. Working with strains of mice which develop these auto-antibodies at an early age, Dr. N. Talal and his colleagues have demonstrated abnormalities of antibody forming cells, the immunoregulatory network, scavenger cells and deficiencies in thymic hormones which, in part, control immune responsiveness. They also have demonstrated that male hormones (testosterone) suppress, and estrogens enhance auto-antibody formation.

Sepulveda VA Medical Center GRECC.—Dr. I. Abrass has demonstrated an age-related decrease in cardiac responsiveness to catecholamine (adrenalin-like) stimulation in the rat. This is thought to be due in part to a decrease in total and catecholamine-sensitive adenylate cyclase (a second messenger system in the expression of hormone activity). In studies of the kinetics of memory formation, Dr. A. Cherkin, using a model of trained suppression of the "innate" peck response of chicks, found that non-toxic levels of L-proline and related compounds cause retrograde amnesia while D-proline and related molecules did not produce this effect. This area of research is thought to be relevant to the elderly with memory loss and the associated conditions of confusion and disorientation.

Shreveport VA Medical Center.—Dr. I. Rouben has found that levels of neurotransmitter catecholamines decline with age in the brain of rats.

Wadsworth VA Medical Center.—Both humoral and cell mediated immune responses decline with advancing age and as a result, vulnerability to certain infectious, autoimmune and neoplastic diseases may increase. Work by the GRECC has shown that (1) regeneration of subsets of T-cells following sublethal irradiation is delayed and the pattern abnormal in middle aged and old mice; (2) loss of immunological vigor in old animals is correlated with thymic involution; (3) chronic viral infection accelerates immunological aging; (4) a protein which binds IgG can be demonstrated on the membranes of old red blood cells and marks the cell for phagocytosis by macrophages; and, (5) impaired immune function in old mice can be partially restored by the simple chemical 2-mercaptoethanol. Work by Dr. M. Tyan has shown that bone changes similar to those seen in osteoporosis of the elderly can be produced in young mice by the transplantation of marrow cells from very old animals. This observation provides a new model for the study of human osteoporosis, a major health problem of the elderly.

Wood VA Medical Center GRECC.—Aging is associated with alteration in mood, thermoregulation, pain threshold, and stress response, and these functions may be modulated by the newly described endogenous opiates (endorphins) and by the pituitary hormone adrenocortico stimulating hormone (AcTH). Gambert, et al., have demonstrated an age-related decline in B-endorphin content of the rat hypothalmus and corpus stratum; ACYH content declined only in the hypothalmus.

CLINICAL STUDIES

American Lake VA Medical Center.—Dr. P. Prinz has shown that the normal aged individual has a disturbed sleep pattern as compared to the normal young.

Bronx VA Medical Center.—Dr. K. Davis has demonstrated in 11 elderly patients with different degrees of memory loss that the cholinergic drug physostigmine has a positive effect on the memory process.

Boston Outpatient Clinic GRECC.—Since 1963, appproximately 2,280 healthy males have been followed in a normative aging study. It has been found that:

(1) Hemoglobin, serum calcium and phosphorous levels decline with age.

(2) Absolute peripheral blood lymphocyte counts do not decline with age.

(3) Rising serum cholesterol levels were significantly correlated with the subsequent development of ischemic heart disease.

(4) Exhaustion, worry and inability to rest were associated with increased frequency of ischemic heart disease, and anger and inability to rest were associated with an increased incidence of hypertension.

(5) People who look older than their chronological age may indeed be biologically older.

(6) Smoking is hazardous to your health. Pulmonary function decreases and blood pressure increases.

(7) There are age-related declines in numerical, spatial and finger dexterity skills, but generally this is less severe for men of high socioeconomic status.

(8) There is a dramatic decline with age in the acquisition and retrieval of new information from long term memory. However, in healthy old men there is no loss in retrieval of familiar, colloquial events.

(9) Bone loss around the teeth, a major cause of tooth loss in the elderly was significantly less in a group of individuals who had taken aspirin daily over an extended period of time.

Lexington VA Medical Center.—It has been suggested that elevated levels of aluminum in the brain may be one of the causes of Alzheimer's disease. A study by Dr. W. R. Markesbery has found that the concentration of aluminum does increase in the brain with advancing age, but that this is not unique to Alzheimer's disease.

Little Rock VA Medical Center.—A mild anemia of unknown etiology is not uncommon among the healthy elderly. Dr. A. D. Lipschitz has found that reduced blood formation may not be a universal effect of the aging process and that some as yet undefined pathologic abnormality may be present in the anemic elderly.

Palo Alto VA Medical Center GRECC.—Using event-related potential techniques it has been shown that, during the performance of a memory retrieval task, old people moved more slowly than young, encoded only slightly more slowly, scanned memory at the same speed, but were considerably less confident about difficult decisions.

San Diego VA Medical Center.—In tissue culture B lymphocytes from the aged (over 75) have been found to be defective in their ability to transform into antibody producing cells, yet they proliferate normally.

Seattle VA Medical Center.—Antipsychotic medications are frequently used in the management of behavioral disorders in elderly demented patients. Murray, et al., have shown that antipsychotic medication was no more effective than placebos for most behavioral problems, and they concluded that antipsychotics should have a relatively limited role in the treatment of demented elderly individuals.

Sepulveda VA Medical Center.—Previous work has shown that there are losses in learning and verbal memory functions with age. The results of a study by Riege, et al., point to performance, but apparently not ability differences in nonverbal memory for which the effects of health, medication, or depression need to be identified.

Wadsworth VA Medical Center.—Dr. J. Hershman reports that the incidence of hypothyroidism in humans increases with age and may reach a frequency of fifteen percent in females during the seventh and eighth decades. This increase may be attributable to chronic lymphocytic thyroiditis.

PSYCHOSOCIAL STUDIES

Brentwood VA Medical Center.—In studies on problem solving in middle-aged and elderly adults, LaRue found that differences in education, health, and age accounted for 15 percent, 9 percent, and 2 percent of the variance in problem solving scores, respectively. Such a finding lends support to the notion that age, per se, has little impact on high-order noncrystallized cognitive processes.

Boston Outpatient Clinic GRECC.—Studies have shown that the elderly do suffer a deficit in the speed with which they become alert, and this is limited to the early stages of the alerting process. Feedback had an alerting effect for the younger subjects, but not for the older ones.

St. Cloud VA Medical Center.—Reminiscing is often regarded as a meaningless wandering of the mind, a sign of deterioration in old age. However, recent research findings and theoretical formulations suggest that it may serve important adoptive functions in maintaining self-esteem, in reinforcing a sense of identity and integrity, and in working through personal losses and current stresses.

12. Education and Training

Every short and long range plan of the VA's Department of Medicine and Surgery dealing with the health care needs of the nation's growing population of elderly veterans includes Office of Academic Affairs sponsored or supervised health manpower training activities to help assure that the highest quality of geriatric care will be available to the aging patients who are eligible for the VA health care system.

The training of all categories of health care professionals for that purpose has always been a priority effort of every affiliation program carried out in VA medical centers and other health care facilities of the system. Work with geriatric patients is an inescapable and integral part of the clinical experience of the nearly 100,000 students and trainees—including 24,000 resident physicians—who work in those VA facilities each year as part of affiliation agreements between virtually all VA health care facilities and the nearly 1,000 health professional schools, colleges and university health science centers.

The Veterans Omnibus Health Care Act of 1976 (Public Law 94–581) and the National Academy of Sciences' 1977 report, "Study of Health Care for American Veterans," highlighted the significant role of the VA in providing leadership in geriatric training by noting that:

"The VA must prepare for large increases in the numbers of veterans eligible for and in need of long-term care. Alternative resources and programs of high quality are less available outside the VA * * * In view of the fact that a higher quality of care is observed in VA hospitals with medical school affiliation, the VA should encourage the development of multidisciplinary gerontology and geriatric programs in the schools with which it affiliates. It is recommended that affiliations be encouraged with schools of medicine, nursing, social work, and allied health, and schools with programs in clinical psychology in which there are programs in gerontology and geriatrics."

The following special programs reflect some of the activities of the Department of Medicine and Surgery, Office of Academic Affairs, which have been responding to these needs:

Geriatric fellowships for physicians.—Although medical educators are divided in their views as to whether or not geriatrics should be a full-fledged specialty in medicine, physicians with special clinical training in geriatric and the requisite skills and knowledge are essential to patient care and to carry out important teaching roles in undergraduate and graduate medical education. The VA, through the patients served in its health care delivery system, its affiliated medical schools, and its intramural research program, is in a favorable position to support the training of physicians in the problems of the geriatric patient. Therefore, a geriatric fellowship program was developed in 1977 as the system's centerpiece for geriatric training through the Office of Academic Affairs. The purpose of the program was to develop a cadre of physicians who would provide national leadership in geriatrics/gerontology. The commitment of the fellows to excellence in geriatric patient care and to innovation in the stimulation of new approaches to geriatric training is already resulting in significant outcomes in the improvement of the health status of older veterans and older patients generally.

The fellowship program is a 2-year educational experience for physicians certified in certain specified specialties. It incorporates into a defined curriculum all the clinical and educational resources needed in the care, treatment, and management of health care of the elderly. The program is conducted at 12 VA medical centers in collaboration with the affiliated medical schools.

The program has attracted high quality physicians with a sincere interest in older patients and their care. Several fellows have published papers on geriatrics, and one fellow coauthored a book on medical ethics and presented a paper at an international geriatric conference in Germany. Seven fellows have also had international rotations in geriatric medicine in the United Kingdom. Only 4 of the 25 fellows entering during the first 2 years did not complete the program for personal reasons.

Of the first group of eight fellows who completed the program, five remained with the VA as full or part-time employees or consultants. In the second group, 9 of the 13 fellows remained in the employ of the agency, seven as geriatricians and two as special associate investigators in geriatrics. These physicians are in great demand. They are being sought by medical schools and other Federal agencies, as well as the VA.

Interdisciplinary team training.—The interdisciplinary team training program has been activated at five VA medical centers, four of which also have a fellowship program. The teams consist of physicians, nurses, psychologists, social workers, therapists, nutritionists, and others. Clinical nurse specialist trainees also rotate on the teams.

The purposes of the interdisciplinary team training program include the development of a cadre of health practitioners with the knowledge and competencies required to provide interdisciplinary team care to meet the spectrum of health care and service needs of the aged veteran. The program serves as a model for VA staff development through regionally focused activities. Further, it provides leadership in interdisciplinary education for VA medical centers and health personnel to function collaboratively with physicians in caring for elderly veterans.

An education program guide in geriatrics was developed for use by the physician fellowship and team training programs. It consists of a compendium of behavioral objectives in geriatrics, an annotated list of print and nonprint materials available in geriatrics, and a list of undergraduate and continuing educational offerings.

Clinical nurse specialist.—Clinical nurse training is another facet of VA educational programs in geriatrics. The need for specially trained graduate level clinical nurse specialists is evidenced by the sophisticated level of care needed by the VA patient population, specifically in the area of geriatrics. Advanced nurse training is a high priority within the VA because of the shortage of such nursing specialists who are capable of assuming positions in specialized care and leadership. The clinical nurse specialist program was established in 1981 to attract clinical specialists to the VA and to meet staffing needs in priority areas in geriatrics, rehabilitation, and psychiatric/mental health, all of which impact on the care of the elderly veteran. Direct student support is provided to nurse specialist trainees for their clinical practicum at the VA medical centers affiliated with the academic institutions in which they are enrolled. In fiscal year 1981, 70 traineeships were supported in 28 VA medical centers; 25 in geriatrics; 11 in rehabilitation; and 34 in psychiatry/mental health.

Continuing education.—Continuing education and in-service education continue to be offered by every VA facility according to identified needs, and geriatric related subjects are in great demand. Regional programs on these subjects are presented by the seven regional medical education centers (RMEC's) for individuals from facilities within the region. Programs are also presented nationally with the audience drawn from the entire system.

Workshops, conferences, seminars, special experiences for professional staff members and staff teams are planned, conducted, and evaluated at the local medical center level by the regional medical education centers and by the VA central office. The programs are often conducted in cooperation with the geriatric research, education, and clinical centers (GRECC's). Examples of recent RMEC programs in these areas include:

—Reality orientation and other supportive care for the aging institutionalized veterans.
—Gerontology and neurological changes.
—Implementation of geriatric nursing standards.
—Cardiopathy of aging, and
—Dental treatment for the geriatric patient.

Cooperative health manpower education program.—The seven VA cooperative health manpower education programs (CHEP, formerly AHEC) established over the last 10 years are also involved in geriatric education in a variety of ways in cooperation with community hospitals and educational institutions. Continuing education programs are conducted for various disciplines with particular emphasis on educational needs of both VA and contract community nursing home staffs. Seminars for large numbers of allied health personnel in the community are also held.

Health manpower training grants.—Several project grants related to geriatrics were funded under the provisions of Public Law 92-541, the VA Medical School Assistance and Health Manpower Training Act, from the time it was enacted in 1972 until the present issue. These have included projects in gerontological nursing, long-term nursing of the aging adult, and a practicum for students in affiliated VA medical centers to expand their knowledge and skills in the care of the aging.

Exchange of medical information.—The exchange of medical information program (EMI) was established in 1967 to benefit patient care at VA medical centers that are remote from major medical teaching centers. This has been accomplished since that time by projects which improve diagnostic, therapeutic and educational activities at related remote medical centers and their surrounding communities. An ever increasing number of projects are now directed to problems of geriatric patients. One example involves remote machine assisted treatment and evaluation of hearing and speech impaired veterans in Alabama which enable them to remain in their homes while receiving therapy. A number of educational programs have been transmitted to remote facilities via an experimental communications satellite. The geriatric programs included topics such as, "Grief and Grieving: You and Your Patient," "Treatment Management of the Geriatric Patient," and "Specialty Support Programs for Older Patients."

Response of the medical schools and medical community.—The close interaction between VA medical centers and their affiliated medical schools has resulted in the gradual development of an increased interest in geriatrics on the part of the wider medical community. The combination of the GRECC's and the geriatric fellow program is beginning to capture the imagination of medical school faculty as a result of the opportunities they offer for teaching and research in long-term care units which have ready access to an acute care setting. A critical mass of physicians with interest and training in geriatrics is evolving. Increasingly, medical schools are conducting continuing education programs, and emphasizing undergraduate and graduate medical education in geriatrics.

Three of our geriatric fellowship program directors are also responsible for the establishment of departments of geriatric medicine in our medical school affiliates. One of the codirectors of the fellowship program has been appointed to a chair in geriatric medicine in the affiliated medical school—the second endowed chair in geriatrics in the United States. VA leadership in geriatrics is recognized by the fact that VA physicians working in geriatrics are in demand as speakers for geriatric societies and professional meetings throughout the country.

Increasingly, there is evidence that medical schools are seeking to establish geriatric units in university hospital settings. At least six former fellows are directing these efforts. Usually these physicians have a part-time appointment at the VA.

The possibility of additional GRECC's as authorized by Public Law 96–330 has stimulated great interest on the part of affiliated medical schools, as well as our VA medical centers. Through the collaboration of various Department of Medicine and Surgery (DM&S) units, criteria for each of the three components of the GRECC have been developed. The Office of Extended Care is willing to share this information upon request.

Interest of students.—The American Medical Student Association (AMSA) established a task force on aging in 1978. Students in all 10 AMSA regions are active in projects relating to the care of the aging. The Office of Academic Affairs plans to nurture this interest to maintain the enthusiasm of the students in the field of geriatrics.

In 1978, the Society for Health and Human Values sponsored an essay contest for health professions students on the subject of "Human Values in the Care of the Elderly." Several VA staff members served as volunteers, with other experts, in reviewing and rating the essays submitted. Two of the contest winners were medical students.

Medical students and residents are learning about geriatric medicine in VA medical centers, especially those with GRECC's and fellowship programs. Through rotations to the GRECC's and other extended care facilities, the emphasis on geriatrics is increasing. First-year residents have been particularly interested in the potential contribution of geriatric medicine to improvement in the quality of life of older patients.

Some students reflect a cultural bias in their lack of interest in the elderly. However, our national preoccupation with youth is diminishing and additional change, albeit slow, is beginning to occur.

One of the indirect but extremely important aspects of improved attitudes and patient care is attributed to the development of an interpersonal process recall (IPR) program initiated at one of the GRECC sites. This is a 10-hour course given to all medical house staff during the first 10 days of their yearly 2-month rotation through the outpatient department. Lectures, videotaping of interviews with patients, and demonstration tapes for discussion have resulted in changed and enlightened attitudes of house staff toward patients in general, and elderly patients in particular.

In conclusion, there is a broad systematic educational and training effort underway in the Veterans Administration's DM&S—both in central office and in the field—which is resulting in improved education of health professionals and in the health care of the elderly. Since its inception, the VA has been devoted to both education and the care of older veterans. The strength of the VA as an educational resource is reflected in its patient population, outstanding research program, and affiliations with schools of medicine and other health professions. It is, and will continue to be, an attractive setting for training in geriatrics. Also, through the GRECC's, specialized getriatric physician and interdisciplinary training, the care and quality of life of the geriatric patient is improving. The training of physician leaders in geriatrics is providing national leadership in geriatrics/gerontology, and a commitment to excellence in geriatric patient care. Geriatrics and geriatric education are high priorities in the VA, and the Office of Academic Affairs is committed to maintaining the leadership role it has established in this important field.

13. Department of Veterans Benefits

COMPENSATION AND PENSION PROGRAMS

Disability and survivor benefits (pension, compensation, and dependency and indemnity compensation) administered by the Department of Veterans Benefits provide all or part of the income for 1,608,412 persons age 65 or older. This total includes 842,934 veterans, 665,253 widows, 82,267 mothers, and 17,958 fathers. Approximately 94,111 veterans age 78 or older receive a 25 percent differential in addition to their pension benefits under Public Law 86-211, as amended.

The Veterans' and Survivors' Pension Improvement Act of 1978, effective January 1, 1979, provided for a restructured pension program. Under this program eligible veterans receive a level of support meeting the national standard of need. Pensioners generaly receive benefits equal to the difference between their annual income from all other sources and the appropriate income standard.

This act provided for an $1,119 increase in the applicable income standard for veterans of World War I or the Mexican border period. This provision was in acknowledgment of the special needs of our older veterans. Pensioners receiving benefits under the prior program were provided the opportunity to elect to receive benefits under the new program.

VETERANS ASSISTANCE SERVICE

Veterans Assistance Service personnel have identified 764 State and area agencies on aging (AAA) to which they have disseminated information on VA benefits and services. Twenty-five regional offices have provided personal contacts in the form of workshops or training, while other offices have maintained relations through telephone calls and mailings.

The Veterans Assistance Service exhibit "Veterans Benefits for Older Americans" highlights, by pictures and accompanying text, the verious benefits explained in the pamphlet of the same title (VA pamphlet 27-80-2). This display and pamphlet were designed to convey the Veteran Administration's concern with the aging veteran population and to prompt further contact with field stations for more information and assistance.

Progress continues on the development of a videocassette containing information on benefits of special interest to the older veteran. It is hoped that this videotape can be made available to senior centers and similar community based Information & Referral agencies.

EDUCATIONAL ASSISTANCE

There are roughly 300 people age 65 or older receiving VA educational benefits, of whom fewer than 200 are training under chapter 34 of the Veterans Readjustment Act of 1966, as amended. Widows of veterans who died of service-connected causes and wives of veterans who are permanently and totally disabled from service-connected disabilities total about 100 of the enrollees in the survivors' and dependents' educational assistance program. Last year, there were some 30 veterans, 65 years of age or older, participating in the vocational rehabilitation program. While no education service, vocational rehabilitation, or counseling service programs are specifically designed as a service to the aged participation in the programs continues to include a small number of aged veterans and eligible dependents.

○